

2016 Access Monitoring Review Plan



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Introduction

The Colorado Department of Health Care Policy and Financing (the Department) administers the State’s public health insurance programs, including Health First Colorado, Colorado's Medicaid Program, and Child Health Plan Plus (CHP+), as well as a variety of other programs for Coloradans who qualify. The Department is the federally designated single State agency to receive Medicaid funding from the federal government for administration of Colorado’s Medical Assistance Program. The mission of the Department is to improve the health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.

Health First Colorado members traditionally included children, pregnant women, those with disabilities, the elderly and aging, and parents. In 2014, under the federal authority of the Patient Protection and Affordable Care Act and State Senate Bill 13-200, the Department expanded Medicaid eligibility to those earning up to 133% of the federal poverty level (hereinafter referred to as expansion adults). The expansion adult demographic group includes adults without dependents and adult parent/caretakers ranging in age from 19 to 64.

During Fiscal Year 2015, more than 1.4 million Coloradans were enrolled in Health First Colorado. Enrollment of expansion adults totaled more than 400,000 as of March 2016.¹ While most Health First Colorado members do not remain on the program for long periods of time, some have lifelong conditions that require long-term enrollment. Data indicates that the number of providers serving Medicaid members has increased along with the number of members accessing services.²

The Department addresses the healthcare needs of our members through a variety of programs. One such example is the Accountable Care Collaborative, or the ACC, which seeks to improve the health of all Medicaid members in the State. Designed to provide added supports for our members, providers, and stakeholders, the ACC also takes wellness and nonmedical needs into consideration.

In October 2015 the Centers for Medicare & Medicaid Services (CMS) issued the final rule "Methods for Assuring Access to Covered Medicaid Services" (CMS-2328-FC), establishing a process for the ongoing analysis and monitoring of Medicaid member access to medical assistance, as is required under section 1902(a)(30)(A) of the Social Security Act. In accordance with 42 CFR 447.203, the Department authored this Access Monitoring Review Plan (Plan). The Plan must include an analysis of data and the State's

¹ Source: DSS Monthly Member Eligibility Table

² Souce: “The Impact of Increased Medicaid Payments for Primary Care Services on Access to Care for Medicaid Members in Colorado” – March 2016

conclusion of the sufficiency of access to care, and is intended to be used to inform state policies affecting access to Health First Colorado services. The Plan must consider:

- the extent to which member needs are fully met;
- the availability of care through enrolled providers to members in each geographic area, by provider type and site of service;
- changes in member utilization of covered services in each geographic area;
- the characteristics of the member population (including considerations for care, service and payment variations for pediatric and adult populations and for individuals with disabilities); and
- actual or estimated levels of provider payment available from other payers, including other public and private payers, by provider type and site of service.

The following service categories provided under a fee-for-service (FFS) arrangement are analyzed in this Plan:

- Primary Care Services
- Physician Specialist Services
- Behavioral Health Services (FFS)
- Obstetric Services (including pre and post-natal services, labor and delivery)
- Home Health Services

Measuring access to care in Medicaid is a complex endeavor. While there is no perfect measurement for evaluating levels of access, the Department has combined several data sets to complete the evaluation. We expect these data sets to evolve over time, both as access information becomes more readily available and as our capacity to understand utilization patterns improves. The Plan includes analysis of administrative claims utilization data, health access survey data, and rate comparison data. One of the most informative claims data access measures is the service penetration rate; this is a percentage calculated by dividing the number of utilizers by the number of total eligible members. It reveals the trend of utilization of a service, which is useful for monitoring how access to those services changes over time. By combining these three sets of data the Department is able to analyze, to the best of our available resources, if individuals covered by Health First Colorado (Medicaid members) have access to healthcare that is comparable to that of the State's general population.

Several factors complicate the ability to analyze access sufficiency. Medicaid expansion in January 2014 introduced a new member demographic to Medicaid whose utilization patterns are not well understood. It can be difficult to draw definitive conclusions regarding changes in utilization observed during this time period, although this information is informative for establishing a baseline for future comparison. Service utilization, in general, does not necessarily indicate access. For instance, claims data may show that a member accessed a specialty surgery benefit; but it does not reveal how difficult it was for them to find that surgical provider or how long they had to wait to obtain the service. Those factors are not captured by administrative claims data, though they may be gleaned through the Colorado Health Access Survey. Since the two data sources cannot be "cross walked" to identify individual member experience, analysis must be completed at a higher level.

Developed during the months of November 2015 through May 2016, the draft Plan was written in consultation with the State Medical Assistance and Services Advisory Council (Colorado's medical advisory committee) and posted on the Department's website for 30 days for public comment. The Plan

makes a final recommendation concerning the sufficiency of access to care for Medicaid members as of 2016 on page 28. Further analysis and explanation can be found in the appendices.

Characteristics of the Colorado Medicaid Population

General Demographics

The population of Colorado was 5.46 million as of 2015 and is rapidly growing, up 6.4% from 2010.³ Health First Colorado provides coverage to more than 20% of the State’s population. A general demographic breakdown of the Health First Colorado population compared to the general Colorado population for 2015 follows:

Statistic	Medicaid	Non Medicaid	All Coloradans
	Percentage	Percentage	Percentage
<i>Gender</i>			
Male	48.5%	50.1%	49.8%
Female	51.5%	49.9%	50.2%
<i>Age</i>			
0 to 18	39.1%	22.5%	25.8%
19 to 64	52.1%	64.4%	62.0%
65+	8.8%	13.1%	12.2%
<i>Race / Ethnicity</i>			
Non-Hispanic White	54.0%	74.1%	70.1%
Non-Hispanic Black	4.5%	2.4%	2.8%
Hispanic	33.6%	17.5%	20.7%
Non-Hispanic Other Race	7.9%	6.1%	6.4%
<i>Income Relative to Federal Poverty Level (FPL)</i>			
At or Below 100% of the FPL	55.9%	16.3%	24.2%
101 - 200% of the FPL	27.5%	19.5%	21.1%
201 - 300% of the FPL	9.1%	17.8%	16.1%
301 - 400% of the FPL	3.7%	16.2%	13.7%
Over 400% of the FPL	3.8%	30.1%	24.9%
<i>Educational Attainment (Ages 19+)</i>			
Less than High School	20.9%	6.0%	8.5%
High School Degree or Equivalent	29.7%	20.2%	21.8%
Some College But No Degree	23.4%	22.3%	22.5%
Associates Degree	10.1%	11.1%	11.0%
College Graduate	13.2%	24.9%	23.0%
Postgraduate	2.7%	15.4%	13.3%
<i>Employment Status (Ages 19-64)</i>			
Employed	61.3%	80.8%	78.4%

³ Source: US Census Bureau

Unemployed, Looking for Work	18.0%	5.6%	7.1%
Not in Labor Force	20.8%	13.6%	14.5%
Health Status			
Excellent / Very Good / Good Health	74.1%	89.9%	86.8%
Fair / Poor Health	25.9%	10.1%	13.2%

Table 1 - Demographic data from the 2015 Colorado Health Access Survey

Medicaid Managed Care

The Department contracts with three managed care networks. Two of the networks are based in specific geographic regions (Denver Health and Rocky Mountain Health Plan), while the third is our Community Behavioral Health Service Program, consisting of five regional contractors, which manages the Behavioral Health benefit statewide. Only a small portion of Medicaid members receive Behavioral Health Services outside of the managed care network.

Managed Care Plan	Members Enrolled FY15	Percent of Total Enrolled FY15
Denver Health and Hospital Authority	93,389	6.39%
Rocky Mountain Health Plan	41,125	2.81%
Community Behavioral Health Service Program	1,363,550	93.3%

Table 2 - Breakdown of Health First Colorado's managed care populations.⁴

Health Statistics Regions

The Colorado Department of Public Health and Environment (CDPHE) has grouped Colorado's 64 counties into 21 Health Statistics Regions (HSRs) for the purpose of public health planning. These 21 HSRs were developed by the Health Statistics and Evaluation Branch of the CDPHE in partnership with state and local public health professionals. HSRs were developed using statistical, demographic, and survey data criteria. HSRs group together counties in which the population coalesces to access health care. Medicaid member population counts within various HSRs vary widely depending on the geographic region. In this Plan, the 21 HSRs are used for the purpose of geographic health care access analysis.

County	HSR Number	County	HSR Number
LOGAN	1	SAN JUAN	9
MORGAN	1	DELTA	10
PHILLIPS	1	GUNNISON	10
SEDGWICK	1	HINSDALE	10
WASHINGTON	1	MONTROSE	10
YUMA	1	OURAY	10
LARIMER	2	SAN MIGUEL	10
DOUGLAS	3	JACKSON	11
EL PASO	4	MOFFAT	11

⁴ Source: DSS unique member count based on capitation payments, made as a percentage of total enrollment for FY15. Based on member monthly eligibility tables.

CHEYENNE	5	RIO BLANCO	11
ELBERT	5	ROUTT	11
KIT CARSON	5	EAGLE	12
LINCOLN	5	GARFIELD	12
BACA	6	GRAND	12
BENT	6	PITKIN	12
CROWLEY	6	SUMMIT	12
HUERFANO	6	CHAFFEE	13
KIOWA	6	CUSTER	13
LAS ANIMAS	6	FREMONT	13
OTERO	6	LAKE	13
PROWERS	6	ADAMS	14
PUEBLO	7	ARAPAHOE	15
ALAMOSA	8	BOULDER	16
CONEJOS	8	BROOMFIELD	16
COSTILLA	8	CLEAR CREEK	17
MINERAL	8	GILPIN	17
RIO GRANDE	8	PARK	17
SAGUACHE	8	TELLER	17
ARCHULETA	9	WELD	18
DOLORES	9	MESA	19
LA PLATA	9	DENVER	20
MONTEZUMA	9	JEFFERSON	21

Table 3 - County/HSR crosswalk

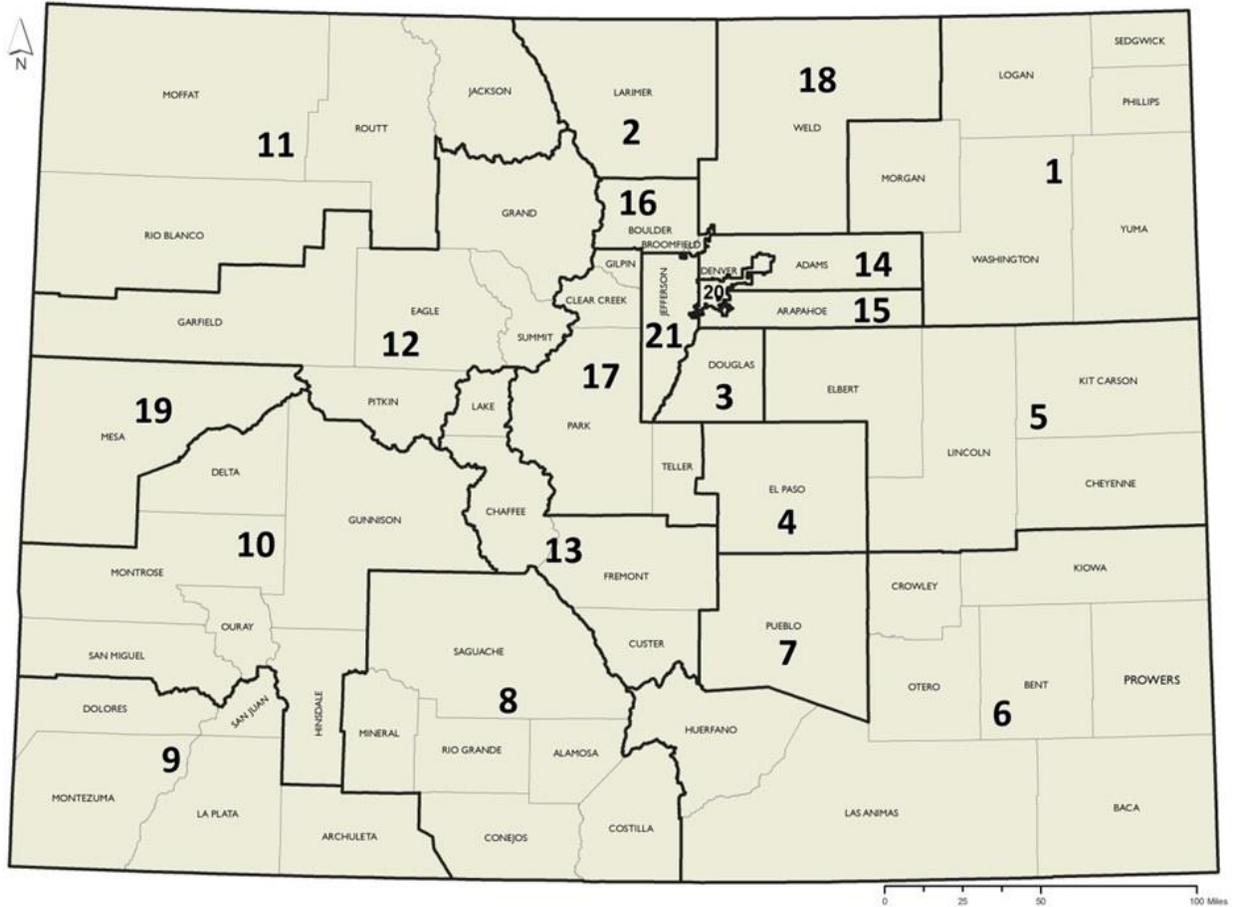


Figure 1 - Map of Colorado Health Statistic Regions

Department Programs and Activities That Ensure Access to Care

The Department continually administers the following programs and procedures to ensure access to care is sufficient for our Medicaid members.

The Accountable Care Collaborative Program

Program Background

The Accountable Care Collaborative (ACC) was launched in 2011 with the intent of making incremental change on a few different fronts: personal health behaviors, access to medical care, good provider-member communication, a connected health system, and access to resources to meet basic needs. The program provides all the usual Medicaid benefits along with added supports to ensure that members get the right care, at the right time, in the right place. The ACC takes wellness and non-medical needs into consideration. The primary goals of the ACC are to:

- Improve member health
- Improve member and provider experience
- Contain costs

Organization of the ACC Program

Colorado is a geographically diverse state, with an urban corridor as well as rural and frontier regions with limited numbers of providers. The State is therefore divided into seven regions, with a Regional Care Collaborative Organization (RCCO) responsible for program execution in each region. These seven RCCO regions were created after analyzing patterns of member utilization and taking natural boundaries like mountains and highways into consideration. The RCCOs contract with Primary Care Medical Providers (PCMPs) to serve as medical homes for Medicaid members. The RCCOs: develop a network of providers; support providers with coaching and information; manage and coordinate member care; connect members with non-medical services; and report on costs, utilization and outcomes for their member populations. Both RCCOs and PCMPs use the Statewide Data and Analytics Contractor (SDAC), a health information technology contractor that analyzes and reports on claims data, to observe patterns in how members are using health care services. During fiscal year (FY) 2015, on a monthly average, there were over 750,000 Medicaid members enrolled in the ACC - approximately 70 percent of all Medicaid members.⁵ Seventy-five percent of ACC enrolled members were connected to a PCMP.

Access to Care in the ACC

The RCCOs act as community conveners, developing partnerships with local health and social service agencies and connecting members to these resources. Often, particularly in our more rural regions, RCCOs help communities to think of creative ways to pool resources and increase access for Medicaid members.

Many providers believe Medicaid members have more complex needs than other populations; many Medicaid members do have advanced chronic conditions or socio-economic factors that make it challenging to provide consistent care. RCCOs play an important role in reducing or alleviating some of the factors that may make Medicaid members more challenging to treat, and they support providers when these factors are present. One of the tools RCCOs use to assist providers in treating Medicaid members is care coordination, a key function of the RCCOs. Care coordinators may work within a medical practice or in the community. Care coordination may include home visits, creation of care plans, health education, and connection to social services like the Supplemental Nutrition Assistance Program (SNAP) or housing. For example, a member might call their RCCO to get help scheduling non-emergent medical transportation, which might make them less likely to miss a medical appointment.

PCMPs also benefit directly from the practice support and practice transformation efforts that the RCCO offers. These supports might include the provision of a care coordinator at the practice, help converting to an electronic health record, the provision of patient screening tools and educational handouts, or help interpreting and understanding the member data available through the SDAC.

Program Improvement Advisory Committee

The advisory structure of the ACC enables administrators to quickly identify member access gaps. A statewide Program Improvement Advisory Committee (PIAC) meets monthly to discuss topics relevant to the ACC. It is composed of: RCCO and Behavioral Health Organization (BHO) representatives; state Medicaid representatives; and members, advocates, and stakeholders from the behavioral, oral, and

⁵ Source: Internal ACC Monthly Management Report

local public health communities. This group discusses program design, quality improvement, and provider- and member-specific issues.

In addition to this statewide group, each RCCO conducts regional PIACs on a quarterly basis. Frequently, these groups are able to identify local-level access issues and challenges faster than the Department can because they are connected to the community. Issues that arise in these local PIACs can then be brought to the Department's attention for our assistance in problem-solving, or the RCCOs may provide a report to the Department of how the community was able to find a solution to a particular challenge. This process allows the Department to keep track of emerging trends and helps to facilitate continuous program improvement.

Continued Health Care Transformation

As the ACC evolves, it will continue to build on the successes of the program's first five years. The ACC was designed with a long-term vision in mind, and the understanding that health system change must be iterative to keep up with an evolving health care system. The program has shown its ability to innovate, to improve member outcomes and reduce health care costs, and is well-poised to continue to do so in the future.

Colorado's Accountable Care Collaborative Regional Care Collaborative Organization Map

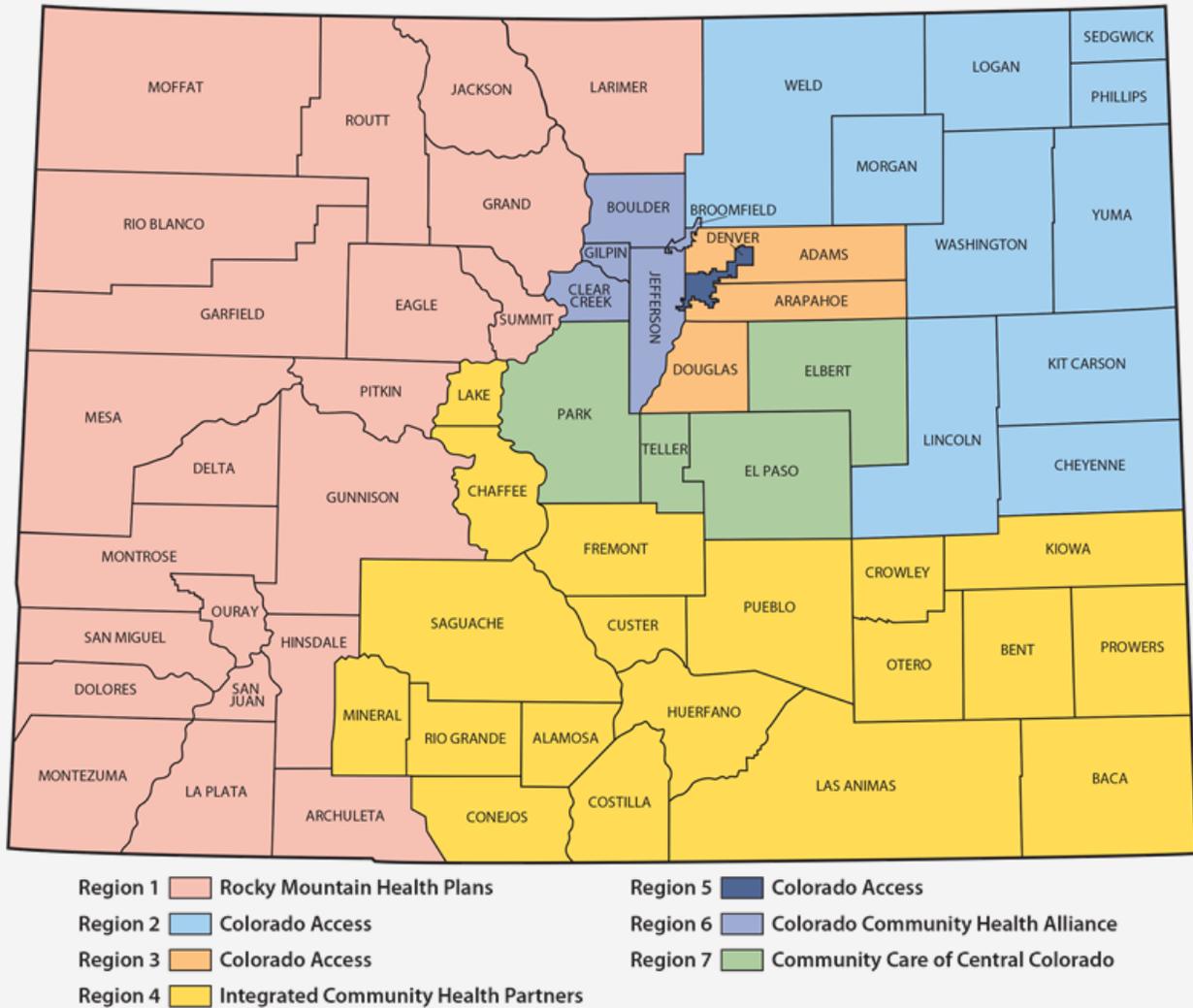


Figure 2 - Map of Health First Colorado Regional Care Collaborative Organizations

Rate Review Process

In 2015, Colorado Revised Statute 25.5-4-401.5 required the Department to create a Rate Review Process and determine a schedule that ensures an analysis and reporting of each Medicaid provider rate at least every five years.⁶ The process includes an analysis of the access, service, quality, and utilization of each service subject to rate review.

The analysis compares the rates paid to Medicaid providers with Medicare provider rates, usual and customary rates paid by private pay parties, and other benchmarks, and uses qualitative tools to assess

⁶ To view five year rate review schedule, visit:

<https://www.colorado.gov/pacific/sites/default/files/Medicaid%20Provider%20Rate%20Review%20Schedule%20FINAL%20October%202015.pdf>

whether payments are sufficient to allow for provider retention and member access and to support appropriate reimbursement of high value services. The findings of this analysis are published in a report on May 1st of each year.⁷

The aforementioned statute also established the Medicaid Provider Rate Review Advisory Committee (MPRRAC). The MPRRAC consists of 24 members appointed by the Legislature to assist the Department in the Rate Review Process. The MPRRAC can recommend changes to the rate review schedule, review and provide input on the analysis report, and conduct public meetings to allow stakeholders the opportunity to participate in the process.

The MPRRAC meets on a bi-monthly basis with additional stakeholder data review sessions during the review process. Data review sessions allow committee members and stakeholders the opportunity to learn about, and discuss, how the Department categorizes services, the methodologies used for pulling utilization data, the potential sources for pulling quality data, and the methods used for analyzing and presenting access data. Additionally, any stakeholder petition or proposal for a rate change is shared with the MPRRAC.

As part of the Rate Review Process, the Department authors a second recommendation report, due to the MPRRAC and Joint Budget Committee on November 1st of each year. The Department works with the MPRRAC and stakeholders to review the May 1st analysis report and develop strategies for responding to the findings within the recommendation report, including any non-fiscal approaches or rebalancing of rates. The recommendation report includes the Department's recommendations regarding the sufficiency of provider rates and includes the data relied upon in making those recommendations.

Access issues are identified through the analysis conducted and within MPRRAC meetings, by engaging with the provider, stakeholder, and beneficiary community.

Regular Feedback Mechanisms

Members of the community, broadly, have the ability to contact, and provide feedback to, the Department online, by phone, in person and by mail. Some feedback avenues are statutorily required, while others have been developed by the Department to help continuously improve our business processes, practices and partnerships.

The Department hosts more than 100 Department councils, committees, work groups and other public meetings that provide a venue to hear from the community in various settings.⁸ These include meetings hosted by, or actively attended by, Department staff, liaisons and subject matter experts.

Mechanisms also exist within local communities for Medicaid members to provide feedback to the Department. Our local County Departments of Human/Social Services and trusted community partners/advocacy organizations often serve as a conduit to provide us feedback on programs,

⁷ To read Rate Review Analysis Report, visit:

<https://www.colorado.gov/pacific/sites/default/files/2016%20Medicaid%20Provider%20Rate%20Review%20Analysis%20Report.pdf>

⁸ To view list of standing stakeholder and committee meetings, visit:

<https://www.colorado.gov/hcpf/committees-boards-and-collaboration>

operations and providers. Additionally, our vendors across the State, including our Accountable Care Collaborative Regional Care Coordination Organizations, Behavioral Health Organizations, Single Entry Points, Community Centered Boards and other service providers have direct, frequent interactions with our members. They provide unique perspectives and feedback on a variety of topics and issues. The Department often calls upon these groups, through formal public meetings or informally, to share community member perspectives. In 2015, the Department also launched two member-only advisory councils that seek to engage members, both in-person and virtually, in the identification of systemic issues, and to work collaboratively with program staff to address them.

Typically, the Department gathers feedback via meetings, website feedback forms, formal and informal requests from elected officials, and solicitations for feedback on proposed projects. This feedback is collected and shared with the appropriate subject matter expert who works to address the identified topic or issue. Sometimes the comments received are part of a larger effort that also includes soliciting feedback from federal partners like the CMS. There are also more informal ways for the Department to identify trends and the needs of our community through analysis of call center questions and volume (see below) or through consultation with our provider network and contractors. This information is also regularly shared with subject matter experts and program staff.

Appendices C, D and E depict existing member, provider and stakeholder feedback mechanisms, respectively. Additionally, each Health First Colorado managed care delivery system is required to collect and address complaints and grievances and pass along to the Department those they are unable to address.

Customer Contact Center

The Customer Contact Center (CCC) staff follow specific protocols to resolve issues reported by members, and document each member interaction as a ticket in the Customer Relationship Manager (CRM) system. Various response protocols are housed within the CRM as "articles" within the CRM Knowledge Base. When a call comes to the CCC concerning providers, CRM articles direct CCC staff to take a variety of actions. For example, certain provider complaints are referred to the Colorado Department of Regulatory Agencies (DORA) and ACC members are often referred to their RCCO. CCC staff assist members to find providers when requested.

For each interaction, the CCC staff creates a ticket, which identifies the "type" of call, and refines this further by identifying a "sub type". Using the Center's CRM software and the ticket types, the CCC can provide detailed information about call volume and call patterns.

Access to care is not explicitly identified as a ticket type; it is possible that access is an underlying issue that goes under represented in the CRM system. For instance, a representative may identify the call type as "Locate Provider", when the member has a provider but is seeking a different provider due to poor access or dissatisfaction. CCC staff identify complaints about providers as ticket type "complaint" and ticket sub-type "provider", which could refer to a complaint about provider access but could also refer to, for example, provider quality.

For calendar year (CY) 2015, inferences can be made using data on calls where staff referred members to their RCCO, provided a new provider option, or referred the caller to the DORA. The CRM allows for

further refinement of the data, if needed in the future, to show additional detail about members or calls.

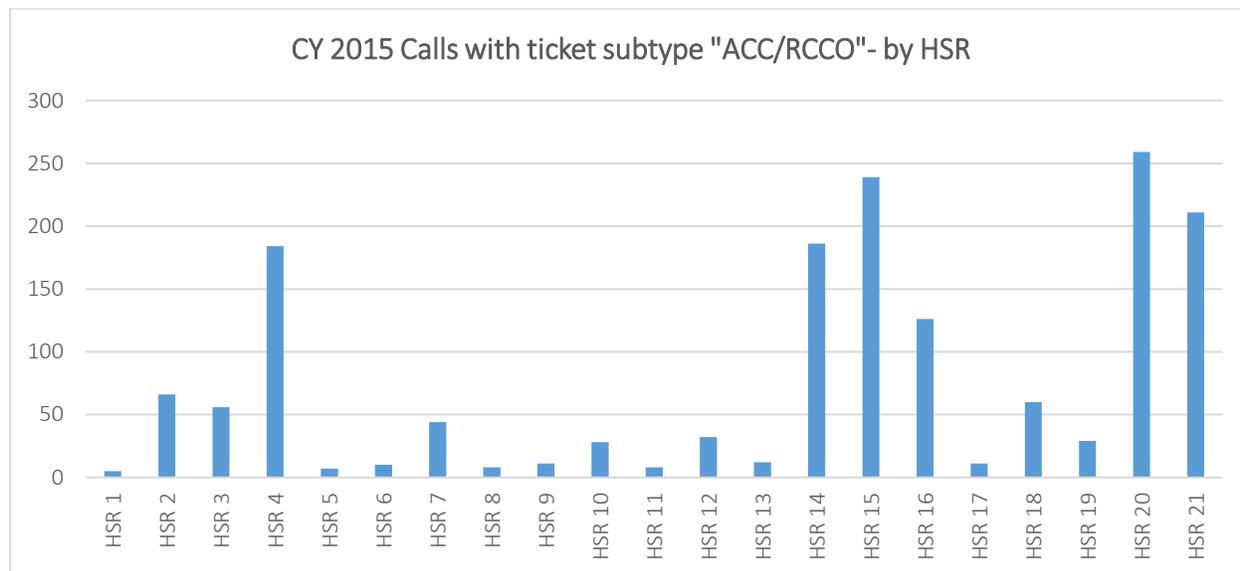


Figure 3 - Customer Contact Center calls referred to a RCCO in CY2015, divided by HSR. ⁹

Within this Plan, information in Figure 3 is cross referenced (where applicable) with the health access survey data and administration claims trend data found in the appendices, to inform access analysis.¹⁰ Analysis is included in the Primary Care Services Direct-to-Staff Input section of Appendix F. Certain HSRs may have more RCCO referrals simply because of their large population volume.

Information available through the CCC’s CRM is a promising source of insight into the Medicaid member experience, which increasingly helps the Department form responses to the needs of our members. The Department plans to explore refining: ticket types within the CRM; and the articles that direct staff to identify access to care issues, which should allow for improved identification of access to care issues reported to Center staff in future Plans.

Nurse Advice Line

The Department operates a nurse advice line. The line provides around-the-clock medical information and advice to Medicaid members 365 days a year. Nurses route callers to the most appropriate source of medical care and assist with the management of some medical conditions, such as asthma and diabetes. Access to care is enhanced by the administration of this service.

Healthy Communities

Healthy Communities is a statewide program administered at the local level by 26 Local Public Health Agencies serving all children (birth through age 20) and pregnant women enrolled in Health First Colorado and the CHP+. More than 100 Family Health Coordinators at these sites generate awareness within their communities about Health First Colorado, help community members to understand the

⁹ Source: Customer Call Center data files

¹⁰ A crosswalk (of CCC data on "provided a new provider option" and "referred the caller to the Department DORA") is not provided, as this data cannot be stratified by service type.

application, eligibility and redetermination processes, and provide application assistance. Family Health Coordinators also reach out to individuals and families when they are first enrolled in Health First Colorado to help them understand their benefits, navigate their respective system(s) of care, find a provider for their general or specialty health care needs, and to establish a medical home.

Family Health Coordinators also work to educate Medicaid members on various aspects of their health care such as the importance of well care visits, immunizations, developmental screenings for children and teens and proper use of the emergency room. Additionally, Family Health Coordinators can help members access their health care by referring them to such programs or community resources as non-emergent medical transportation, child care and child care subsidies, food or housing assistance programs, and low income energy assistance programs, etc.

This program ultimately works to enhance member access to healthcare services.

Access Monitoring Review Plan Data Requirements

Fulfills requirement 42 CFR 447.203(b)(1)

Fulfills requirements 42 CFR 447.203(b)(1)(i) through (v); met within the each Access Monitoring Analysis, attached to this document as appendix items.

Fulfills requirement 42 CFR 447.203(b)(4)

Data Sources

Data for the access review contained within this document comes from three primary sources:

- administrative claims within the Medicaid Management Information System(MMIS), stored in the Decision Support System(DSS) data warehouse;
- the 2013 and 2015 Colorado Health Access Surveys, conducted by the Colorado Health Institute; and
- rate comparison data.

Methodologies and Assumptions

Administrative Claims Data

The administrative claims data analyzed in this Plan was queried from the DSS, the warehouse for all Health First Colorado electronic provider claims data. All queried data was fit into a standard information template (or “data package”) containing data information pertinent to measuring access to care, so that data analysis could be conducted uniformly across service categories.

Administrative claims data has limitations which complicate the ability to analyze access sufficiency. Twelve to eighteen months must pass after all services are rendered before the complete utilization picture can be seen within the claims data. Utilizer counts, provider counts and penetration rates reported within this Plan run through June 30, 2015.¹¹ There are also inherent limitations of ICD-9 diagnosis coding and provider familiarity with how to correctly code a claim (e.g. select the procedure that most accurately reflects the service actually rendered). Many times the diagnosis coding on a claim will be vague, without much detail as to condition. We anticipate the data integrity of claims to improve

¹¹ The second iteration of this Plan will include claims data beginning July 1, 2015.

with the recent implementation of the ICD-10 code set in October 2015. All of the utilization data presented in this report includes ICD-9 coding.

Data Points

The following utilization data points were pulled from administrative claims data for analysis. An explanation follows of why each is relevant.

- Active billing provider longitudinal count, stratified by Health Statistic Region (HSR).
 - This metric depicts whether the number of active service providers increased or decreased in each geographic region. Trends are examined in monthly increments, from January 1, 2014 through June 30, 2015. *Fulfills requirement 42 CFR 447.203(b)(1)(ii)*
- Utilizer longitudinal count, stratified by HSR.
 - This metric depicts whether the number of service utilizers increased or decreased in each geographic region. Trends are examined in monthly increments, from January 1, 2014 through June 30, 2015. Note: an upward or downward trend in the metric, alone, does not indicate member need for the service; a decrease may signal that members no longer require the service due to positive health outcomes. *Fulfills requirement 42 CFR 447.203(b)(1)(iii)*
- Service longitudinal penetration rate, stratified by HSR.
 - The penetration rate is a statistic calculated by dividing the number of service utilizers by the total number of members eligible to receive the service. A penetration rate trend line establishes the baseline rate at which beneficiaries typically utilize a service. Large deviations in the trend, which do not appear cyclical, could signal an access to care issue that needs further investigation. Trends are examined in monthly increments, from January 1, 2014 through June 30, 2015. *Fulfills requirement 42 CFR 447.203(b)(1)(iii)*
- FY2015 snapshot of age groups by utilizer count.
 - This metric depicts the age distribution of service utilizers which informs the Beneficiary Characteristic description. *Fulfills requirement 42 CFR 447.203(b)(1)(iv)*
- FY2015 snapshot of demographic groups (children/adults/individuals with disabilities) by utilizer count.
 - This metric depicts the group distribution of service utilizers which informs the Beneficiary Characteristic description. *Fulfills requirement 42 CFR 447.203(b)(1)(iv)*

Demographic Technical Definitions:

- **Child:** means any child member, age 20 and under, with an eligibility type of:
 - AFDC/CWP Children
 - Foster Care
 - BC Children (child dependents of a woman enrolled in the Breast and Cervical Cancer Program).

- **Adult:** means any adult member, ages 21 and over, with an eligibility type of:
 - OAP-A (old age pension)
 - AFDC/CWP Adults
 - BC Women
 - Non-Citizen (emergency)
 - Qualified Medicare Beneficiaries (QMB)
 - SLMBs (Medicare enrolled)
 - Legal Immigrant Prenatal
 - MAGI Adults
- **Individual with a Disability:** any adult or child member, of any age, with an eligibility type of:
 - OAP-B-SSI
 - AND/AB-SSI
 - Buy-in: Working Adults with Disabilities
 - Buy-in: Children with Disabilities
- FY2015 Snapshot of gender groups by utilizer count.
 - This metric depicts the gender distribution of service utilizers which informs the Beneficiary Characteristic description. *Fulfills requirement 42 CFR 447.203(b)(1)(iv)*
- FY2015 Snapshot of Billing Provider type by utilizer count.
 - This metric depicts the distribution of billing provider types, within the service category, who deliver the benefit. *Fulfills requirement 42 CFR 447.203(b)(1)(ii)*
- FY2015 Snapshot of place of service by utilizer count.
 - This metric depicts the distribution of place of service (the setting where the service was delivered) within the service category. *Fulfills requirement 42 CFR 447.203(b)(1)(ii)*
- FY2015 Snapshot of top 10 diagnoses by utilizer count.
 - This metric depicts most common beneficiary needs (diagnoses) of those receiving the service. *Fulfills requirement 42 CFR 447.203(b)(1)(iv)*

Colorado Health Access Survey

The 2013 and 2015 Colorado Health Access Surveys (CHAS) contains demographic comparisons of Medicaid members to the rest of the Colorado population, as well as access to care measurements from both the 2013 and 2015 CHAS broken out by geography, payer, and other demographics.¹²

The 2013 CHAS was conducted as a telephone survey of 10,224 randomly-selected households in Colorado; the 2015 CHAS was a telephone survey of 10,136 households. The CHAS was administered

¹² For more information about the CHAS and to view CHAS results, see: <http://coloradohealthinstitute.org/>

during the spring of each reporting year by Social Science Research Solutions (SSRS), an independent research company contracted by the Colorado Health Institute (CHI).

Survey data were weighted by CHI to accurately reflect the demographics and distribution of the State's population. Missing values for income variables were inputted using a regression approach. To ensure statistical soundness, results with small pre-weighted sample sizes and/or large confidence intervals were excluded from the access to care data.

In many cases where percentages did not vary greatly year to year, the number of people in that group still grew substantially. For example, the percentage of Medicaid members who visited a health care professional did not change much between 2013 and 2015. Yet many more individuals were enrolled in Health First Colorado in 2015, which increases the denominator. The actual number of members who reported visiting a health care professional increased by 72% (497,199 to 854,941).

In some instances, the CHAS sample size was not large enough to report a value. Due to missing values, totals do not always match the sums by demographic. Additionally, these values are based on survey data and may not match official Health First Colorado caseload figures.

The term 'significant' is used throughout this report when discussing CHAS data. It refers to differences, between populations and between years, that are statistically significant at the 95% confidence level, meaning differences between two groups are only 5% (or less) likely to have occurred by chance. To be clear, a 5% significance level is not the same as a 5% difference between two values. While CHAS graphs in this Plan may depict differences greater than 5%, such differences may not be statistically significant because factors such as sample size and the number of respondents to a particular question did not allow CHI to establish significance at the 95% confidence level. Likewise, differences of less than 5% may still be statistically significant if the sample size is large enough.

Data Points

For the Primary Care analysis the following CHAS data points are analyzed:

- Visited a health care professional
- Had a preventive care visit
- Potential access issues
- Last ER visit was for non-emergency
- Went to ER due to convenience
- Told doctor was not accepting new patients

For Physician Specialist Services the following CHAS data points are analyzed:

- Visited a specialist in last 12 months
- Told doctor wasn't accepting insurance type

The Department believes that, while there is no absolute metric to assess access to care, the above survey points, evaluated together, are suitable proxy metrics.

Prenatal Care Statistics

Information about prenatal care rates comes from the birth certification form medical staff fill out and send to the public health department when a child is born in Colorado. The form includes questions

about prenatal care. Those compiled answers are presented in this report, stratified by HSR, for the purposes of analyzing access to care across payers.

Data Points

The following data point is included to complete the analysis of Obstetric Services access to care.

- Prenatal Care Initiation
 - This metric depicts the extent to which prenatal care was reported as *not* received by the mother in the county (HSR) of her residence, delineated by payer source. While this metric cannot draw a strict correlation between prenatal care delivery and access to Obstetric Services in general (due to uncontrollable factors as simple as the mother not seeking prenatal care), it does highlight the differences between the populations served by the Department and other payers.

Thresholds and Baselines

Fulfills requirement 42 CFR 447.203(b)(1)

The data sets above were evaluated together to make an initial assessment with regard to access sufficiency. In addition, these data sets will serve as initial baseline trend data for future access monitoring analyses. We expect these data sets to evolve over time, both as access information becomes more readily available and as our capacity to understand utilization patterns improves.

With respect to the ‘service penetration rate’, which is derived from administrative claims data and represents the percentage of the eligible Medicaid population that utilized services, the Department will flag potential access issues in future analyses whenever the average baseline penetration rate dips below 75% for two consecutive quarters. Such a continued reduction would indicate an anomalous trend and is enough of a reduction to filter out claim noise or billing anomalies which result from temporary billing behaviors and other data factors unrelated to access.

Access Monitoring Review Plan Comparative Payment Rate Review

Fulfills requirement 42 CFR 447.203(b)(3)

Medicaid payment rates are compared to private payer and Medicare payment rates, by provider type and site of service, as applicable. Private payer rate information comes from the Colorado APCD (all payer claims database) which is run by CIVHC (Center for Improving Value in Health Care). The Colorado APCD (www.comedprice.org) is a secure database that includes claims data from commercial health plans (large group, small group, and individual), Medicare and Medicaid. Created by legislation in 2010, and administered by the Center for Improving Value in Health Care, the APCD is the most comprehensive source of health claims data from public and private payers in Colorado.

This is the only source of comparable private payer rate information to which Department has access. The availability of comparable rates varies greatly depending on the service being analyzed, and the way each payer codes for reimbursement of the service. For instance, if the Department reimburses a specific service using revenue codes, while private payers use the Healthcare Common Procedure

Coding System (HCPCS) codes, it would not be possible to accurately crosswalk the equivalency of the two rates and thus no comparison would be available to publish in each Access Monitoring Analysis for that service.

Data Limitations

The data used to calculate the average commercial rate comes from the Colorado All Payer Claim Database (COAPCD) provided by the Center for Improving Value in Health Care (CIVHC). This data contains claims from 2011 through 2015. As there were very few claims from 2015, the average was calculated using claims from only 2014. Additionally, the only information provided about the source of this data is that it “includes claims data from commercial health plans (large group, small group, and individual)”. Detail regarding *which* health plans was not provided. It is possible that the commercial claims are from a limited number of insurance companies and, therefore, may not be representative of Colorado as a whole.

Medicare rates data used for this analysis did not vary by place of service. Therefore, the rate comparison table displays the same rate difference compared to Medicare for each place of service, as calculated by the aggregate of all procedures analyzed.

Methodology

The 2014 CIVHC rates are an average rate calculated using commercial health plan claims from the COAPCD. First, the commercial health plan claims were isolated and then these claims were separated by code and averaged. Rate comparison tables found in the Plan show percent differences as either positive or negative. Negative percent differences indicate the Medicaid rate is lower than the rate it is compared to; positive differences indicate the Medicaid rate is higher than the rate it is compared to.

Access Monitoring Review Plan Beneficiary and Provider Input

Fulfills requirements in 42 CFR 447.203(b)(2)

Fulfills requirement 42 CFR 447.203(b)(7)

Direct-to-Staff Input

Department staff occasionally receive unsolicited input directly from beneficiaries, providers, and stakeholders concerning access to care for services while performing their operational duties. Staff address and catalogue those access comments in accordance with the procedures detailed in Appendix A.

Targeted Stakeholder Input and Input from General Public Notice

This Plan was sent to key stakeholders and was made publically available on the Department’s website for 30 day public comment. The Department also sent notice to the State’s tribes. The public comment period opened on June 9, 2016 and closed on July 25, 2016. Feedback and input was accepted through email and through an online survey and is summarized in Appendix K.

The input received was used to inform both the final layout and formatting of the Plan and the final analysis of sufficiency of access to care for services under review.

Medical Advisory Committee Consultation

Fulfills requirement 42 CFR 447.203(b)

The Plan was also drafted in consultation with the Department's State Medical Assistance and Services Advisory Committee. The committee was created in 1967 and operates in accordance with 42 CFR 431.12 based on section 1902(a)(4) of the Social Security Act. It was established as the Colorado State Medical Assistance and Services Advisory Council under Section 25.5-4-203 C.R.S. (Colorado Revised Statutes).

The Colorado State Medical Assistance and Services Advisory Committee exists to improve and maintain the quality of the Medicaid program by:

- Contributing specialized knowledge and experience to that available within the Department of Health Care Policy and Financing, and
- Providing a two-way channel of communication with the individuals, organizations, and institutions in the community that, with the administrating Agency, provide and/or pay for medical care and services.

The committee is composed of a variety of providers including: doctors, a nurse, a behavioral health specialist, pharmacist, dentist, optometrist, and citizen representatives who advise the Department on clinical policy and who also serve as liaisons between the Department and providers.

The input received was also used to inform both the final layout and formatting of the Plan and the final analysis of sufficiency of access to care for services under review.

Mechanisms for Ongoing Beneficiary and Provider Feedback

Fulfills requirement 42 CFR 447.203(b)(7)(i-iii)

The mechanisms put in place for ongoing provider and beneficiary feedback are depicted in Appendix A – Access Issue Workflow. The Department will promptly respond to this public input and will maintain a record of the input which includes a description of the actions taken to address it. This record will be made available to CMS upon request.

State Agency Recommendations on the Sufficiency of Access to Care

Fulfills requirement 42 CFR 447.203(b)(1)(i)

Fulfills requirement 42 CFR 447.203(4)

The Department recognizes the difficulties that some individuals encounter when accessing their health care services.

The Department has in place numerous programs and processes to help ensure and improve access to care for its members. While there are inherent difficulties in precisely measuring the sufficiency of access to care, and while there may be examples of access challenges at the individual member level (as explained in the public comment section), it would be inaccurate and misleading to characterize Health First Colorado's level of access to care as insufficient.

Members were able to access services as expected over the period of time analyzed in this Plan. In most HSRs, and for all service categories analyzed in this Plan, both the number of utilizers and the number of active providers were either trending steady or rising. Both metrics alone indicate a positive trend for access sufficiency. There were some regions of the State in which the data indicated a need for close monitoring, but the data does not indicate an access issue at this time. Service penetration rates in most HSRs fell from January through May 2014, however, it is believed this is due to the increase in eligible members resulting from Medicaid expansion, who may not utilize services at the same historical rates previously seen.

While certain CHAS survey metrics indicate potential differences in the member experience of accessing care, in general, CHAS data showed Medicaid member access was on par with that of the general population. This suggests that care needs are broadly being met. Further data gathering will be conducted in the coming years to examine access sufficiency in greater detail.

Stakeholders shared anecdotal reports of access concerns to certain services, in certain regions and for certain demographic groups (refer to Appendix K). Where detailed data was provided or where this information could be corroborated to some extent by the data available, the Department flagged a potential access issue for further investigation or indicated that the trend will be closely monitored.

The Department's analytical conclusion is that Primary Care, Physician Specialty, Behavioral Health (FFS), Obstetric (including labor and delivery), and Home Health Services are sufficient to enlist enough providers so that services are available at least to the extent they are available to the general population in each geographic area, pursuant to section 1902(a)(30)(A) of the Social Security Act.

Access Monitoring Review Plan Timeframe

Fulfills requirement 42 CFR 447.203(5)(i-ii)

Beginning October 1, 2016, the Department will submit to CMS the Access Monitoring Review Plan (Plan). By July 1 of each subsequent review period (every three years) the Department will submit to CMS an updated Plan.

The Plan, and its subsequent updates, will include a complete analysis of the data collected using the methodologies described in the 'Access Monitoring Review Plan Data Requirements' portion of the Plan, with a separate analysis for each service. Complete analysis of each service will be documented in the Plan appendices. Services analyzed include:

- Primary Care Services (see Appendix F)
- Physician Specialist Services (see Appendix G)
- Behavioral Health Services (FFS) (see Appendix H)
- Obstetric Services (see Appendix I)
- Home Health Services (see Appendix J)

Special Provisions for Proposed Provider Rate Reductions or Restructuring

Fulfills requirement 42 CFR 447.203(b)(6)

The Department shall submit, with any State Plan Amendment that proposes to reduce provider payment rates or restructure provider payments, an Access Monitoring Analysis Review, in accordance with the Plan. Monitoring procedures (described in the 'Monitoring Procedures' subsection of this Plan) will be put in place for a period of at least three years after the effective date of any State Plan Amendment that authorizes the payment reductions or restructuring.

Addressing Access Questions and Remediation of Inadequate Access to Care

Fulfills requirement 42 CFR 447.203(8)

Procedures to Periodically Monitor Access

Fulfills requirement 42 CFR 447.203(b)(4)

Periodic 3-Year Monitoring

Every three years after October 1, 2016, the Department will submit to CMS an updated version of the Plan by July 1 of that review period. If provider rates are reduced or restructured in a given year, the associated service(s) will also be monitored for a period of at least three years and the Department will submit to CMS a separate Access Review by July 1 each year for three subsequent years. *Fulfills requirements in 42 CFR 447.203(b)(5)(i) and 42 CFR 447.203(b)(6)(ii).*

Monitoring Procedures

Fulfills requirement 42 CFR 447.203(b)(6)(ii)

As part of the Department's ongoing activities to ensure sufficient access to care for our members, service utilization will be monitored annually in accordance with the utilization metrics and methodologies described in the 'Access Monitoring Review Plan Data Requirements' section.

When data analysis identifies an Access Issue, the Department will initiate a process to examine the utilization data in greater detail. After further data examination, the Department will coordinate with local entities (such as the Regional Care Collaborative Organizations) to investigate the issue. If the issue is substantiated it will be escalated to an Access Deficiency, which triggers the requirements of 42 CFR 447.203(8).

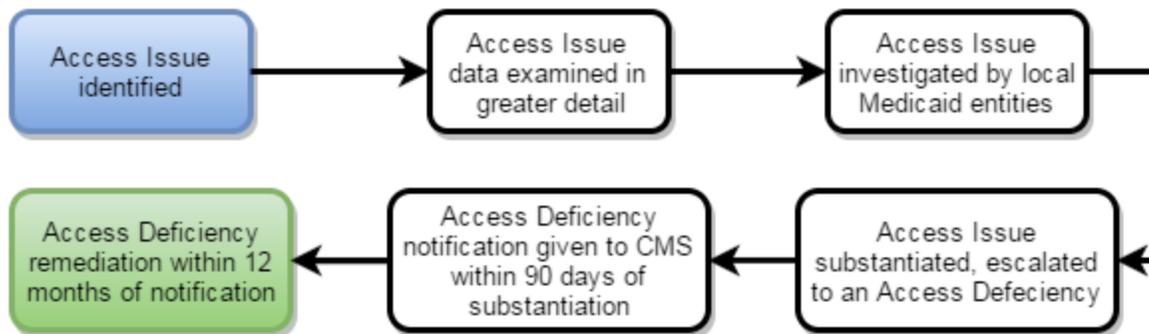


Figure 4 – Diagram of access monitoring procedure workflow

See Appendix A – Access Issue Workflow

See Appendix B – Utilization Monitoring Workflow

Remediation of Inadequate Access to Care

Fulfills requirement 42 CFR 447.203(8)

If an Access Deficiency is identified the Department will notify CMS within 90 days. The notification will include a Corrective Action Plan, which details specific steps and timelines to remediate the access deficiency within 12 months.

Appendix A: Access Issue Workflow

Fulfills requirement 42 CFR 447.203(b)(8)

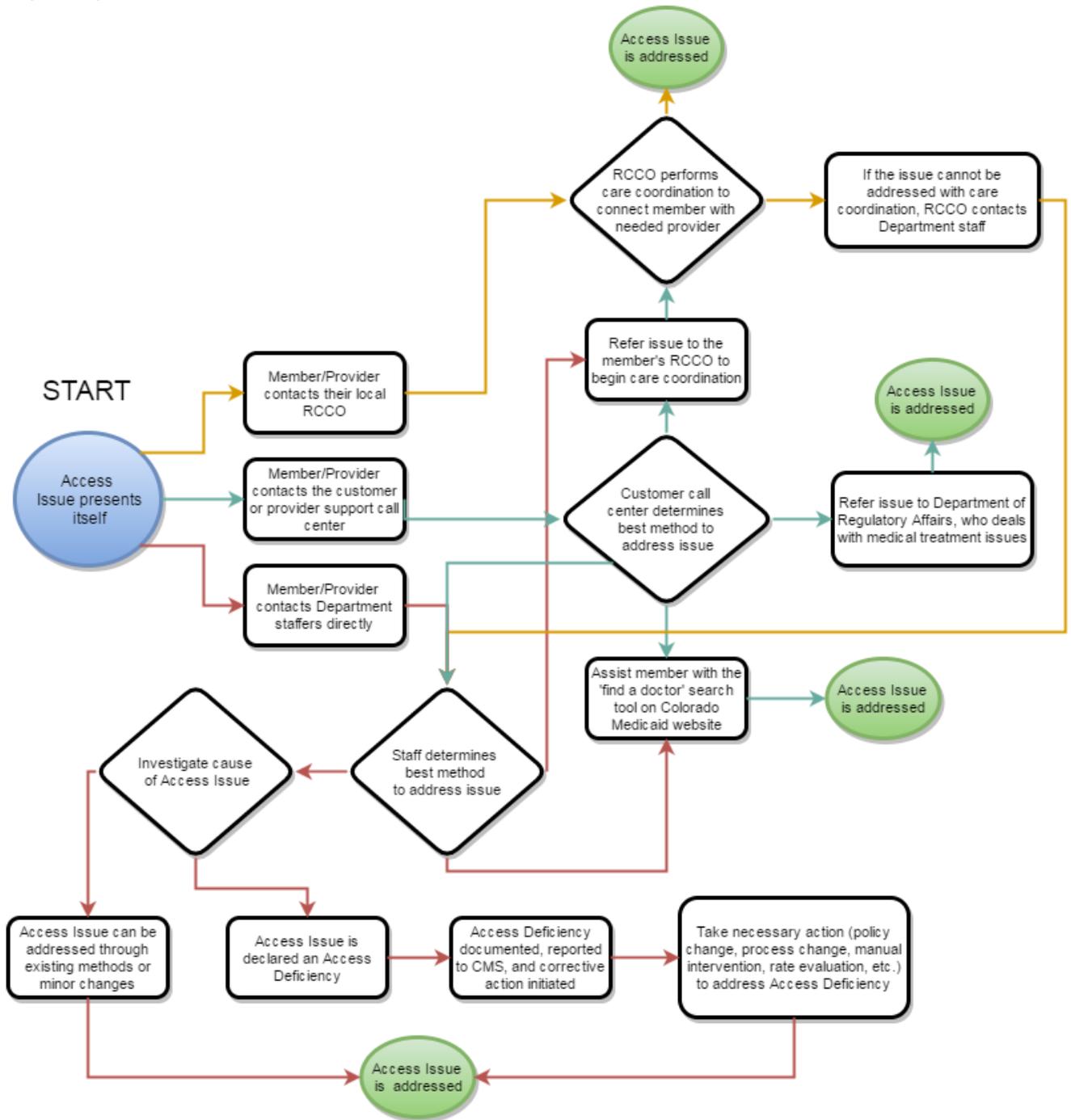


Figure 5 – Diagram of access issue workflow

Appendix B: Utilization Monitoring Workflow

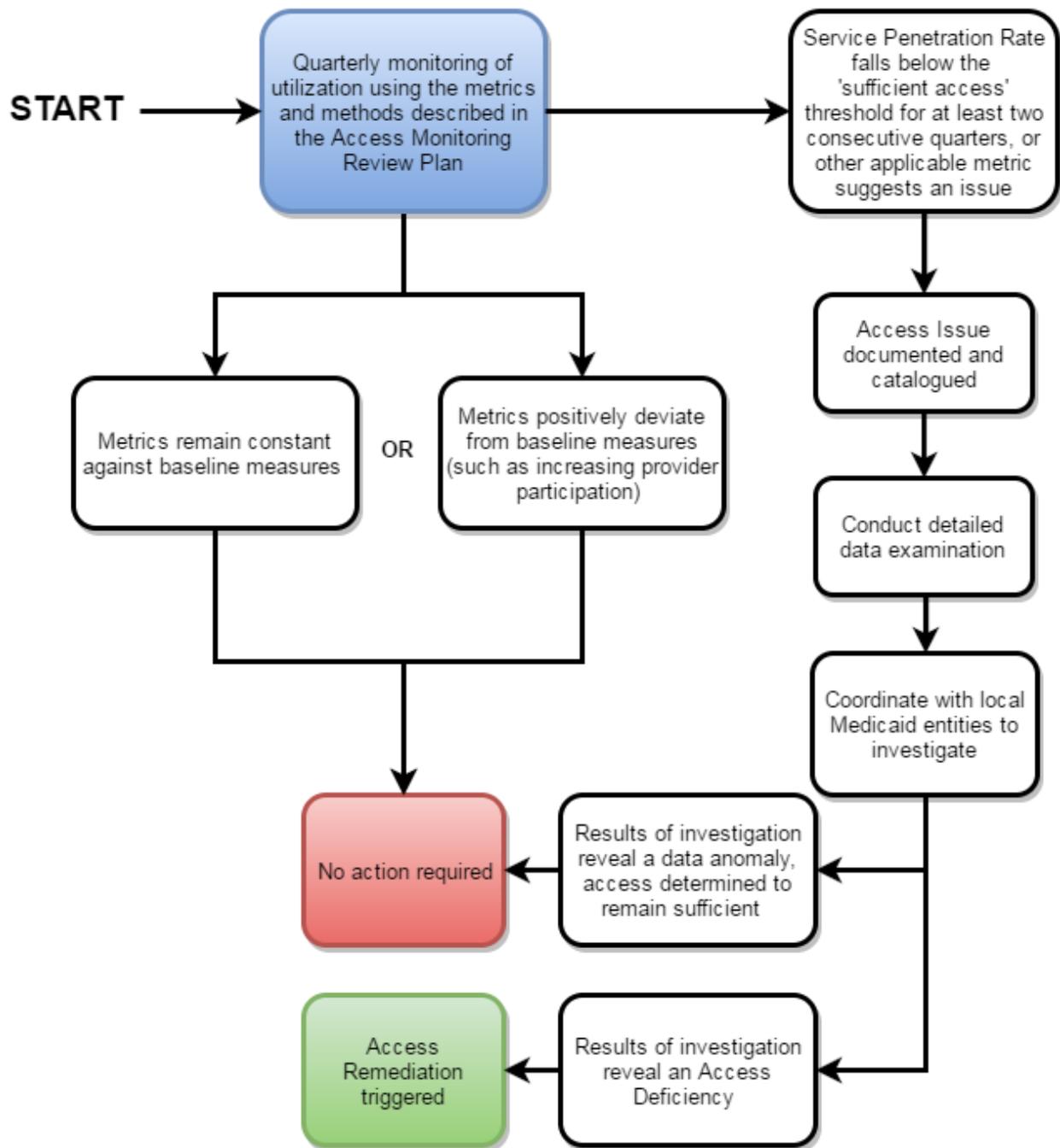


Figure 6 – Diagram of utilization monitoring workflow

Appendix C: Medicaid Member Feedback Mechanisms

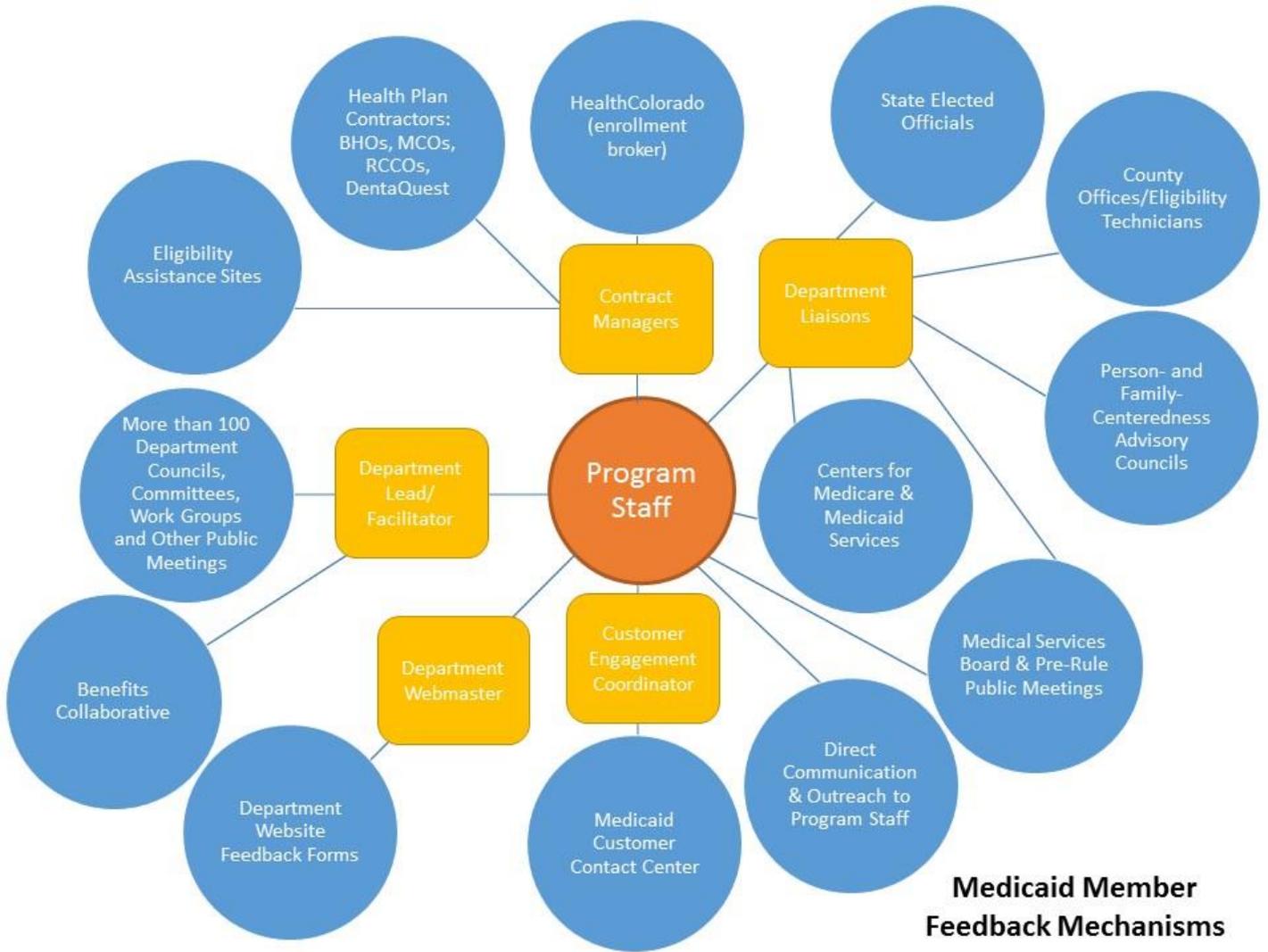


Figure 7 – Medicaid member feedback mechanisms

Appendix D: Provider Feedback Mechanisms

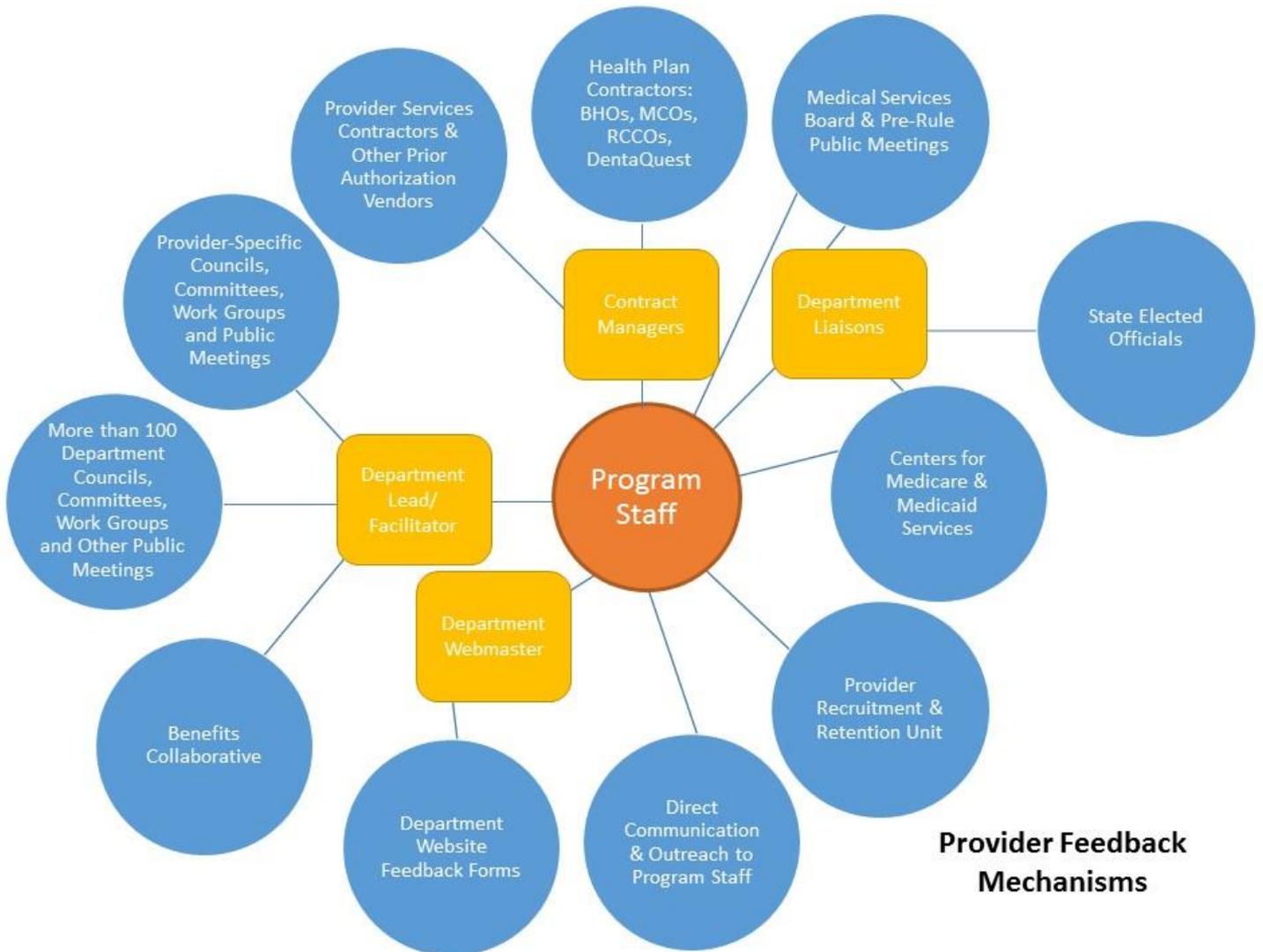


Figure 8 – Provider feedback mechanisms

Appendix E: Stakeholder Feedback Mechanisms



Figure 9 – Stakeholder feedback mechanisms

Appendix F: Access Monitoring Analysis – Primary Care Services

Fulfills requirement 42 CFR 447.203(b)(5)(ii)(A)

Definition of Service

Primary care is generally the first level of contact the public has with the medical care system. Primary care addresses a large majority of personal health care needs including routine care and evaluation of chronic or complex issues. All Health First Colorado members are eligible to receive Primary Care Services.

Characteristics of the Beneficiary Population

Fulfills requirements 42 CFR 447.203(b)(1)(iv)

Utilization of Primary Care Services is depicted in the figures below. While utilization information is useful for understanding demographic differences in utilizer concentration, it must be analyzed in combination with other statistics to make a determination of access sufficiency.

Children visit a primary care provider more often than adults, to evaluate growth. Adults use Primary Care Services for specific issues and for prevention.

Administrative Claims Utilization Data

Figure 10 is a FY 2014-15 snapshot of demographic groups (children/adults/individuals with disabilities) by utilizer count. This depicts the demographic group distribution of service utilizers, which informs the Beneficiary Characteristic description. *Fulfills requirement 42 CFR 447.203(b)(1)(iv)*

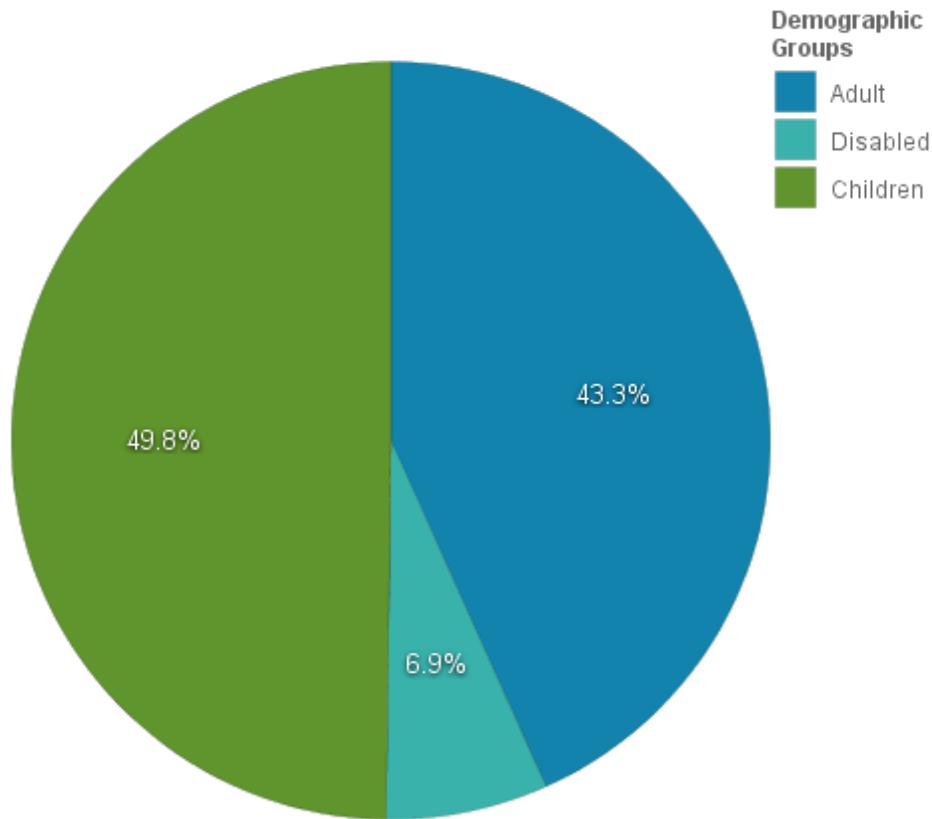


Figure 10 – Primary Care Services utilizers, by demographic groups

Analysis of Demographic Groups:

The distribution of utilizers was similar to the distribution observed among the entire Health First Colorado population. This statistic is consistent with expectations, and does not suggest an access issue, but can only be interpreted in context with other statistics.

Figure 11 is a FY 2014-15 snapshot of gender groups by utilizer count. This depicts the gender distribution of service utilizers. *Fulfills requirement 42 CFR 447.203(b)(1)(iv)*

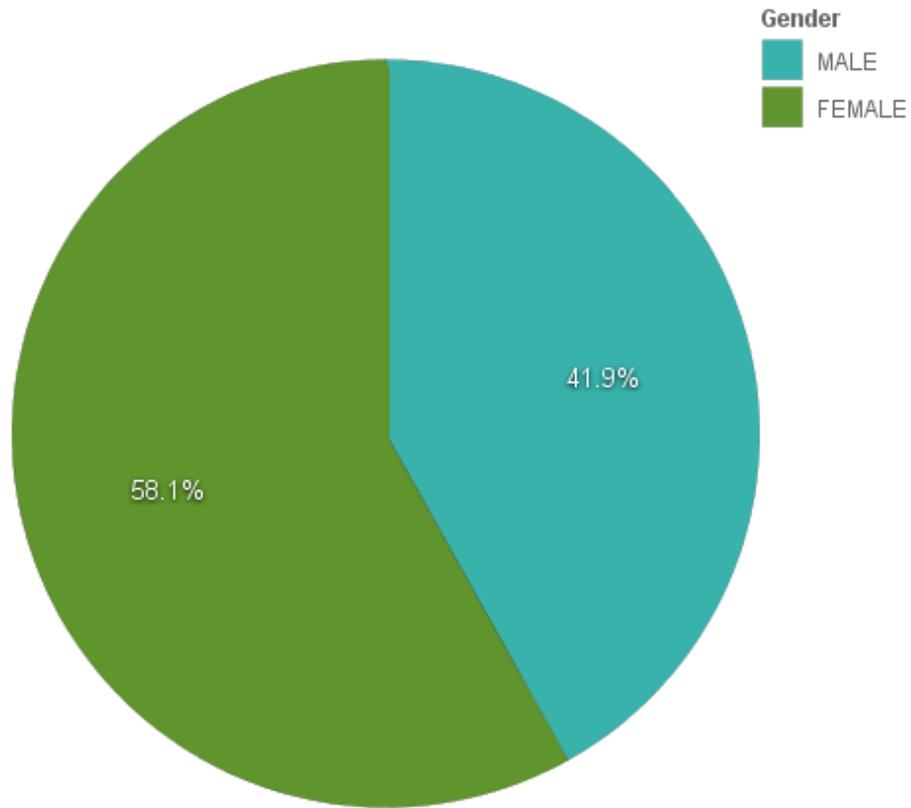


Figure 11 - Primary Care Services utilizers, by gender

Statistics of Gender Group Utilization:

Given pregnant women utilize Primary Care Services at a higher rate, many more females utilized Primary Care Services than males. This statistic is consistent with expectations, and does not indicate an access issue, but can only be interpreted in context with other statistics.

Figure 12 is a FY 2014-15 snapshot of age groups by utilizer count. This depicts the age distribution of service utilizers. *Fulfills requirement 42 CFR 447.203(b)(1)(iv)*

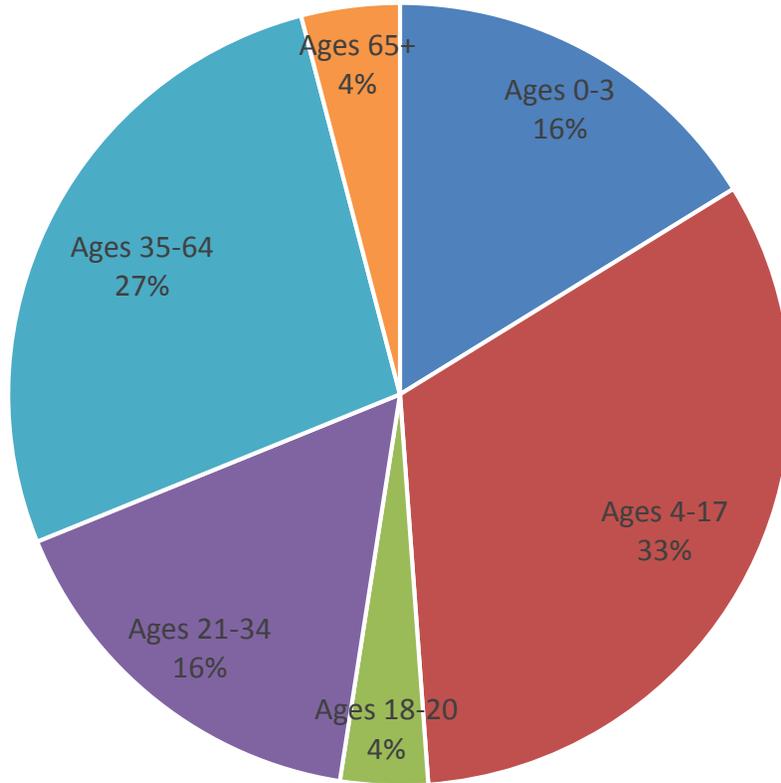


Figure 12 - Primary Care Services utilizers, by age

Analysis of Age Groups

The distribution of utilizers was similar to the distribution of the entire Health First Colorado population. This statistic is consistent with expectations, and does not indicate an access issue, but can only be interpreted in context with other statistics.

Table 4 is a FY 2014-15 snapshot of top 10 diagnoses by utilizer count, further broken out by demographic group. It includes what percentage of total service utilizers each demographic group constituted. This characterizes the needs of the beneficiary population. *Fulfills requirement 42 CFR 447.203(b)(1)(iv)*

Top 10 Root Diagnosis Codes		
Rank: 1 Principal Diagnosis V20		
Code Description HEALTH SUPERVISION OF INFANT OR CHILD		
Total Members: 197,253		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	141	0.1%
Children	194,099	98.4%
Individuals with Disabilities	3,013	1.5%
Rank: 2 Principal Diagnosis V04		
Code Description NEED FOR VACCINATION AND INOCULATION		
Total Members: 71,370		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	17,638	24.7%
Children	49,795	69.8%
Individuals with Disabilities	3,937	5.5%
Rank: 3 Principal Diagnosis V06		
Code Description NEED FOR PROPHYLACTIC VACCINATION AND INOCULATION AGAINST COMBINATIONS OF DISEASES		
Total Members: 35,656		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	10,035	28.1%
Children	24,789	69.5%
Individuals with Disabilities	832	2.3%
Rank: 4 Principal Diagnosis V70		
Code Description GENERAL MEDICAL EXAMINATION		
Total Members: 34,437		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adult	27,306	79.3%
Children	4,166	12.1%
Individuals with Disabilities	2,965	8.6%
Rank: 5 Principal Diagnosis 465		
Code Description ACUTE UPPER RESPIRATORY INFECTIONS OF MULTIPLE OR UNSPECIFIED SITES		
Total Members: 29,951		
Demographic Groups	Utilizer Count	Percent by Demographic Group

Adults	7,503	25.1%
Children	21,052	70.3%
Individuals with Disabilities	1,396	4.7%
Rank: 6 Principal Diagnosis 780		
Code Description GENERAL SYMPTOMS		
Total Members: 25,310		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	14,304	56.5%
Children	8,075	31.9%
Individuals with Disabilities	2,931	11.6%
Rank: 7 Principal Diagnosis V72		
Code Description SPECIAL INVESTIGATIONS & EXAMINATIONS		
Total Members: 24,642		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	19,160	77.8%
Children	3,921	15.9%
Individuals with Disabilities	1,561	6.3%
Rank: 8 Principal Diagnosis V76		
Code Description SPECIAL SCREENING FOR MALIGNANT NEOPLASM		
Total Members: 24,601		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	21,771	88.5%
Children	Blinded	
Individuals with Disabilities	Blinded	
Rank: 9 Principal Diagnosis 250		
Code Description DIABETES MELLITUS		
Total Members: 23,608		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	18,827	79.7%
Children	333	1.4%
Individuals with Disabilities	4,448	18.8%
Rank: 10 Principal Diagnosis 401		
Code Description ESSENTIAL HYPERTENSION		
Total Members: 21,724		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	18,453	84.9%
Children	147	0.7%

Individuals with Disabilities	3,124	14.4%
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Table 4 - Top 10 root diagnosis codes for Primary Care Services utilizers

Analysis of Top 10 Diagnoses

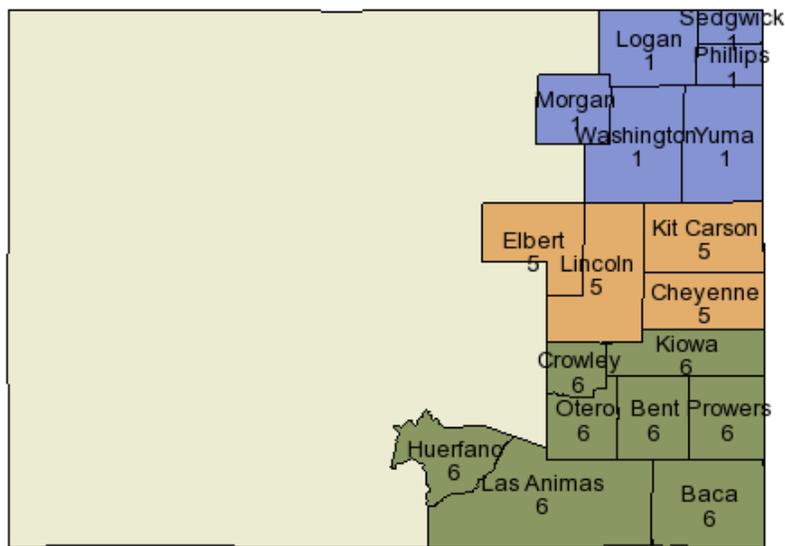
The top diagnoses are as expected. Primary care was heavily utilized for vaccine administration and general medical examinations. Had the primary diagnoses not included these diagnoses, further investigation would be warranted to ascertain why. As the top diagnoses are consistent with expectations, these statistics do not indicate an access issue, but cannot be interpreted in isolation.

Primary Care Services Utilization Analysis by Geographic Region

To best review access to health care services for Medicaid members, using administrative claims utilization data, the Department plotted three sets of data points, stratified by each HSR. These were the total volume utilizer count, the active billing provider count, and the service penetration rate. What follows is a graphical examination of 18 month trends for each of seven groupings of HSRs. Only the utilization of members for whom Health First Colorado was the payer are shown.¹³

HSRs 01, 05, and 06

Predominately rural, in geographical terms, these HSRs account for approximately 3.1% of the State's overall population.



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Figure 13 - Diagram of HSRs 01, 05, 06

¹³ If Medicaid members utilized other services that were paid for by their private insurance or Medicare, that utilization is not captured here.

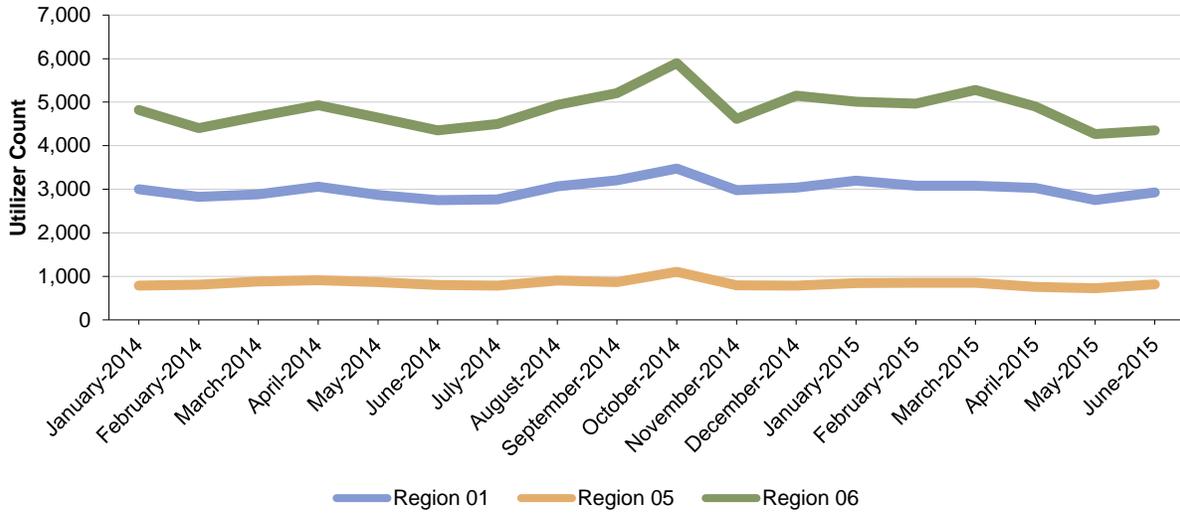


Figure 14 - Primary Care Services utilizer count, HSRs 01, 05, 06

Region 06 had a higher utilizer count than Regions 01 and 05. Indeed, the population of Medicaid members in Region 06 was almost equal to the combined populations of the other two regions in this HSR.¹⁴

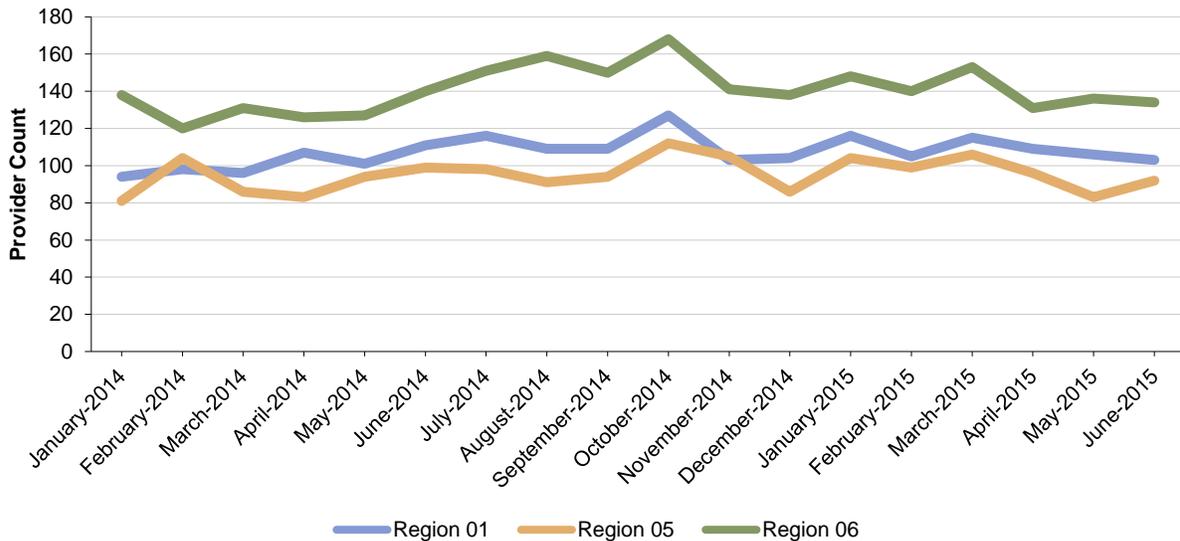


Figure 15 - Primary Care Services provider count, HSRs 01, 05, 06

Similarly, the provider count for Region 06 was higher than that of Regions 01 and 05. The number of providers for Regions 01 and 05 were also approximately half of the number of providers in Region 06. This appears to make sense, given the proportion of Medicaid members in each region.

¹⁴ Source: Colorado Health Institute, 2013 and 2015 Access to Care Report

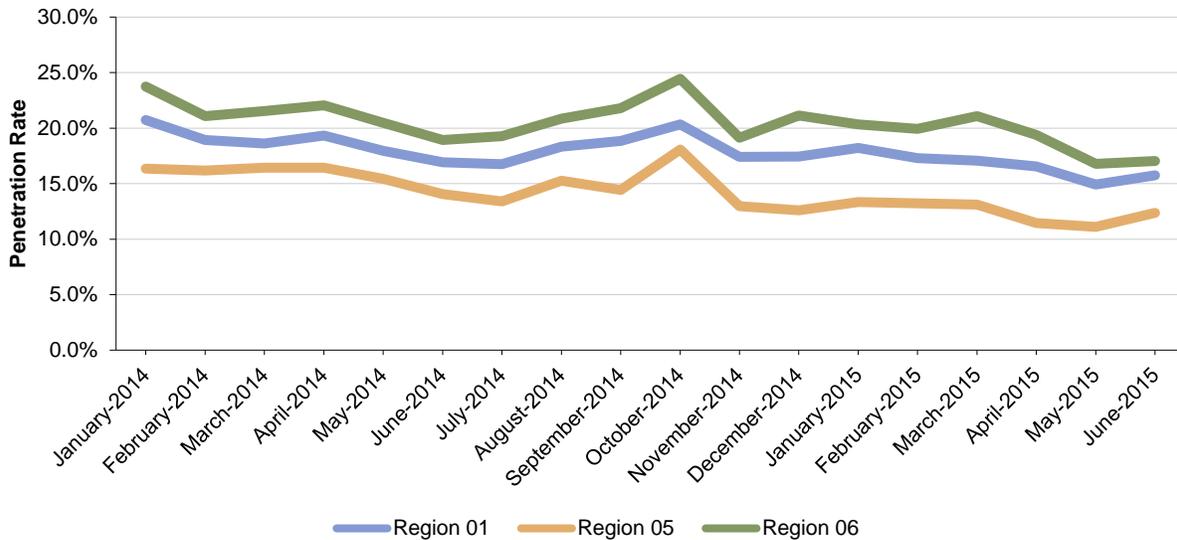


Figure 16 – Primary Care Services penetration rate, HSRs 01, 05, 06

While there appears to have been a slight dip in penetration from January 2014 to June 2015, the decrease is not indicative of an access issue because it coincided with Medicaid expansion, thus increasing the denominator in the calculation which determines penetration rate. Region 06, with the largest population of both members and providers, experienced the largest percentage of penetration year-over-year. While Regions 01 and 05 demonstrated lower percentages of penetration, the decline is not necessarily indicative of an access issue.

Analysis for HSRs 01, 05, and 06

Based on the graphs above, trends appear relatively stable for all three utilization statistics. The penetration rate declined in January-July 2014 because of the increase in total Medicaid population due to Medicaid expansion, which began January 2014. Such a decline does not indicate diminishing access to services.

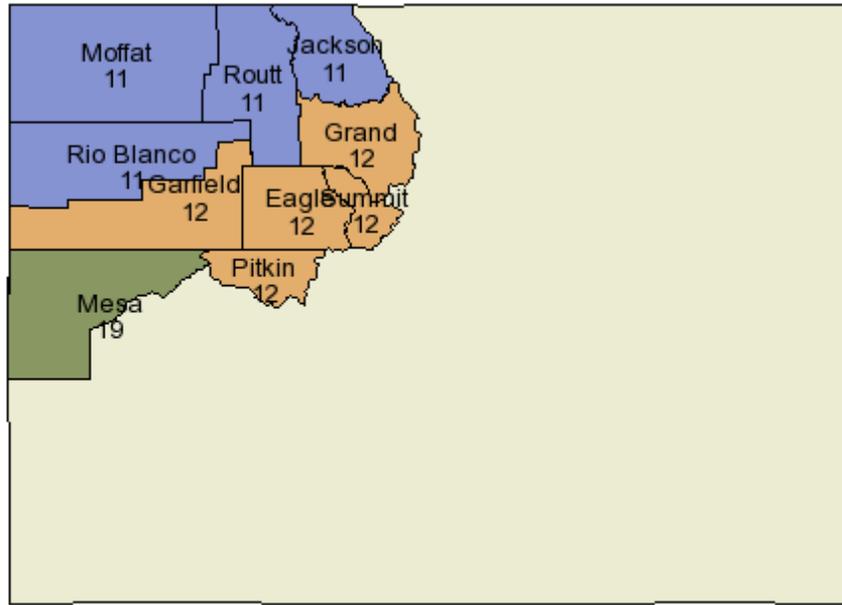
In 2013, 92% of Medicaid members surveyed in Regions 01, 05, and 06 reported access to a usual source of care (USOC), as compared to individuals with other insurance types, of which 93% reported having a USOC.¹⁵ And while those figures slightly decreased in 2015, from 93% to 92% for other types of insurance and from 92% to 88% for Medicaid members, the decrease was not enough to signal an access issue.

As is common in rural communities, there were fewer doctors per patient; this does not indicate an issue with Medicaid member access to primary care that is not also present for health care payers in general.

¹⁵ Source: Access to Care CHAS data from 2013 and 2015; Colorado Health Institute. USOC includes doctors' offices, hospital ERs, community health centers, etc.)

HSRs 11, 12, and 19

Health Statistic Regions 11, 12, and 19 are comprised of residents from the north-western part of the State. These HSRs are predominately rural and mountainous, with one major urban center, and account for approximately 5.8% of the State's overall population.



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Figure 17 - Diagram of HSRs 11, 12, 19

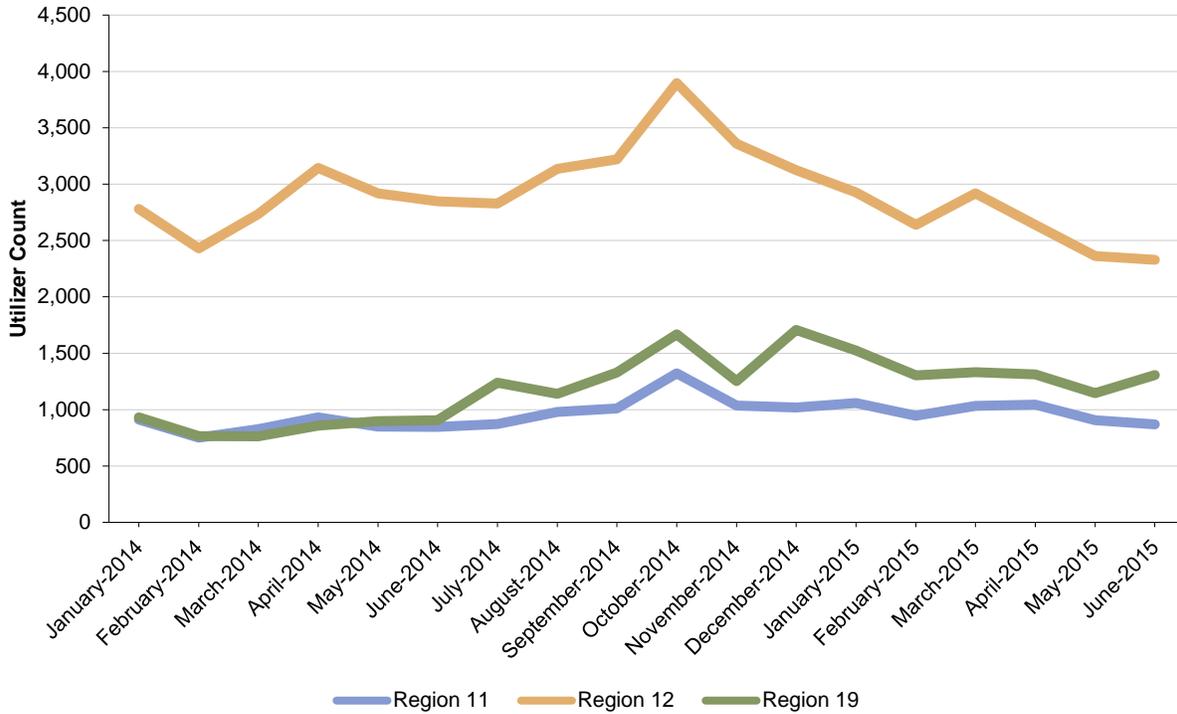


Figure 18 – Primary Care Services utilizer count, HSRs 11, 12, 19

Region 12 had a higher utilizer count than Regions 11 and 19. Data showed that members in Region 12 accounted for approximately 45% of overall insured persons for this geographic area in both 2013 and 2015.¹⁶

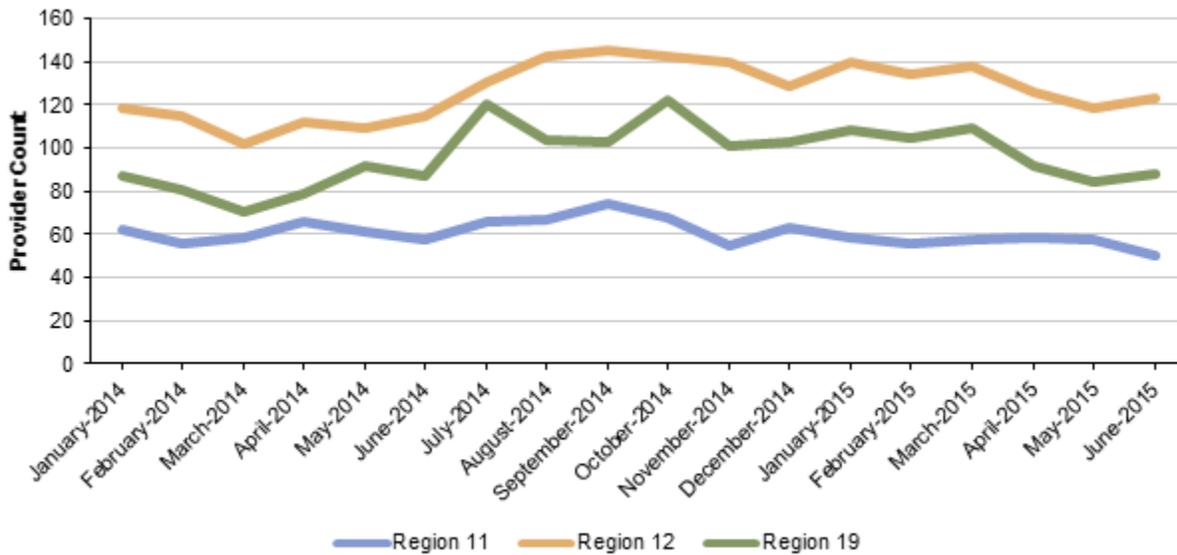


Figure 19 - Primary Care Services provider count, HSRs 11, 12, 19

¹⁶ Source: CHAS Data, Colorado Health Institute, 2013 and 2015

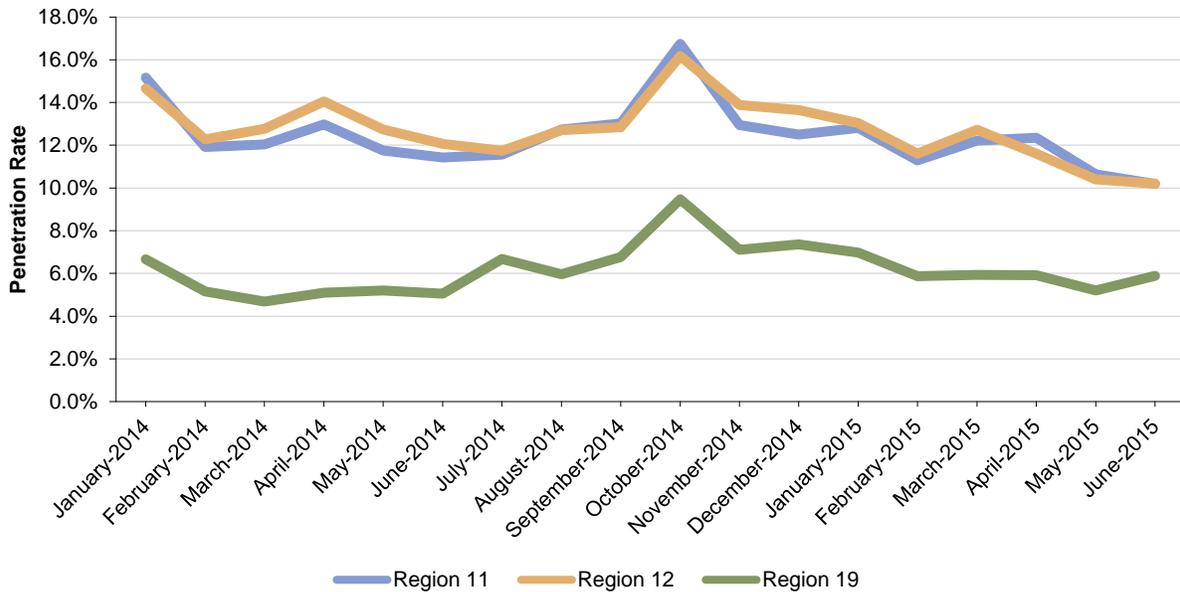


Figure 20 – Primary Care Services penetration rate, HSRs 11, 12, 19

Looking at provider counts, Region 12 had a larger member to provider ratio. In general, data for Regions 11 and 12 showed a higher penetration rate than Region 19. Mesa County, in HSR 19, accounted for only 26% of the overall insured persons for that region, and only 11% of overall insured persons for the three regions combined.¹⁷

Analysis for HSRs 11, 12, and 19

The low rate of providers compared to members in Region 19 is due to the fact that Rocky Mountain Health Plan (RMHP) operates as a Medicaid managed care entity in that region.¹⁸ Therefore, the trend is somewhat misleading at first glance.

The RMHP Prime counties include Region 19 (Mesa County), a portion of Region 12 (Garfield, Pitkin), a portion of Region 10 (Montrose and Gunnison), and a portion of Region 11 (Rio Blanco). Within these RMHP Prime counties, the population remaining under Medicaid fee-for-service includes: adults enrolled in the Medicare-Medicaid Program demonstration (in which Medicare is primary payer for the claims covered under this analysis); all children who qualify for Medicaid in the region (except a few who have a disability status); individuals who are newly eligible for Medicaid prior to their passive enrollment in RMHP Prime; and any individuals who have opted-out of RMHP Prime.

The timing for the observed changes within Region 19 (Mesa County) matches the change in enrollment, from when all eligibility categories were able to voluntarily enroll with RMHP, to a process where most adults were passively enrolled in RMHP Prime, and most children were passively enrolled within a Medicaid fee-for-service payment model. This shift in enrollment is also true for Montrose and Rio

¹⁷ Source: 2015 CHAS Survey Data. USOC includes: doctors' offices, hospital ERs, community health centers, etc.)

¹⁸ Data regarding the managed care delivery model is not reported here because it is outside the scope of the Plan.

Blanco counties, however, this change is likely not as evident as these counties are within a larger multi-county region.

As penetration rate trends were relatively stable for all three HSRs year-over-year, we must assume that this data indicates access to services did not diminish during this time period. This statistic does not indicate an access issue.

HSRs 08, 09, and 10

Health Statistic Regions 08, 09, and 10 are comprised of residents from the south-western part of the State.

Predominately rural and mountainous, these HSRs account for approximately 3.6% of the State's overall population.

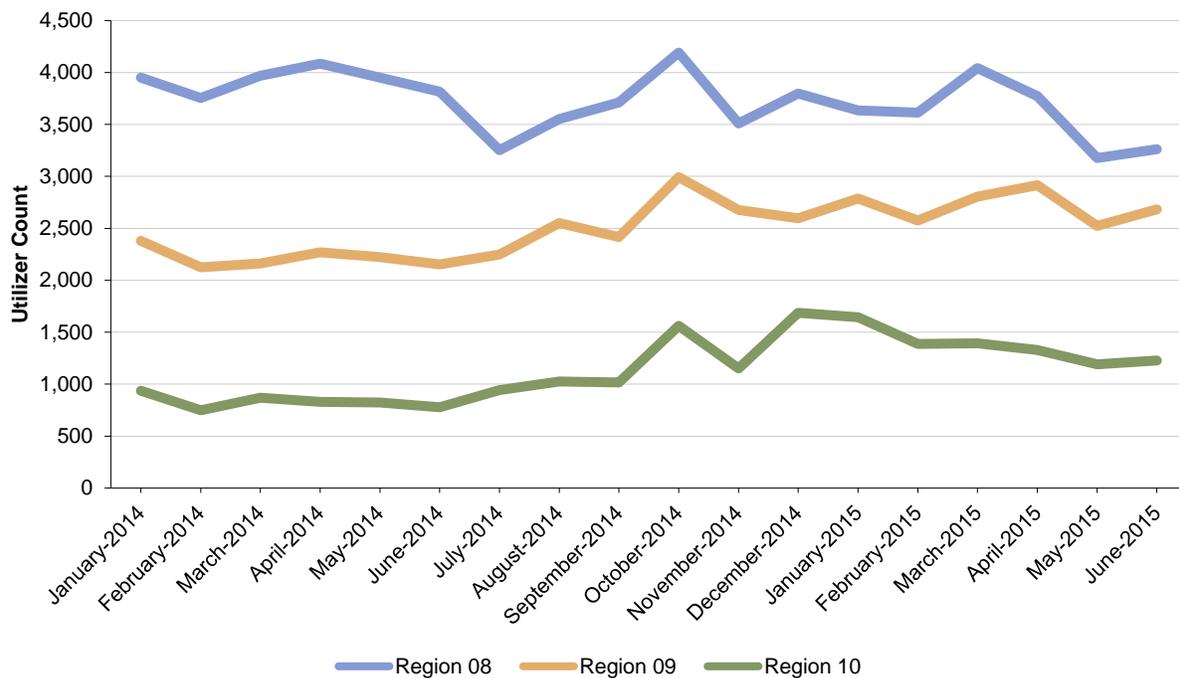


Figure 21 - Primary Care Services Utilizer Count, HSRs 08, 09, 10

The overall population of these three regions is not large. Region 08 appears to have had the largest population of Medicaid members compared to those in Regions 09, and 10. The number of overall insured persons in Regions 09 and 10 was more than double that of Region 08.¹⁹

¹⁹Source: CHAS, Colorado Health Institute 2013 and 2015

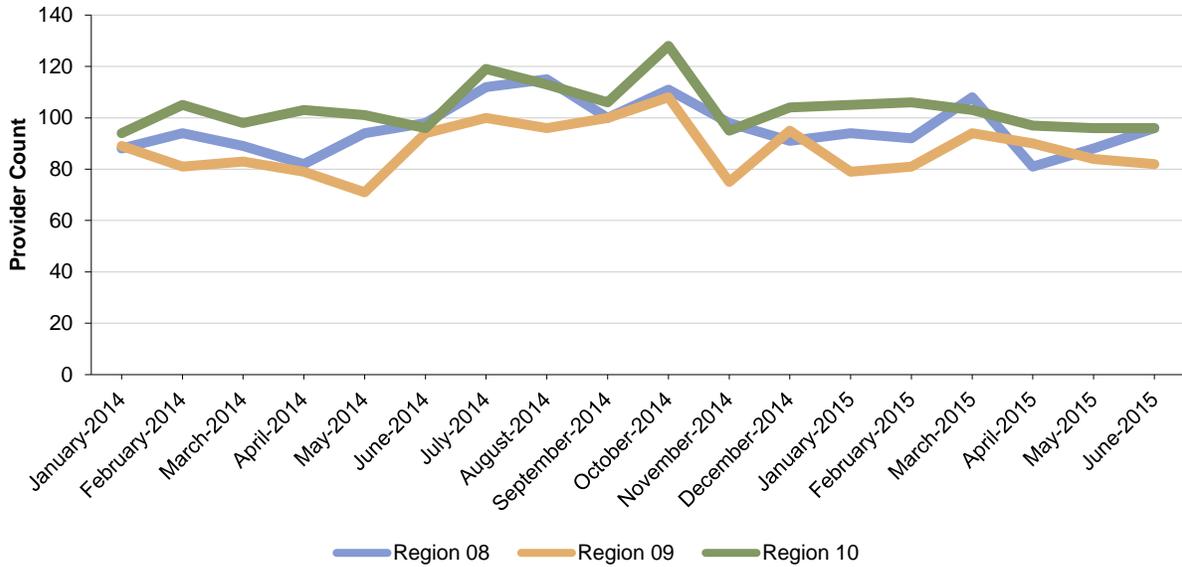


Figure 22 - Primary Care Services provider count, HSRs 08, 09, 10

The same trend applied to the number of providers, which was relatively similar for all three regions, despite Regions 09 and 10 having larger Medicaid populations.

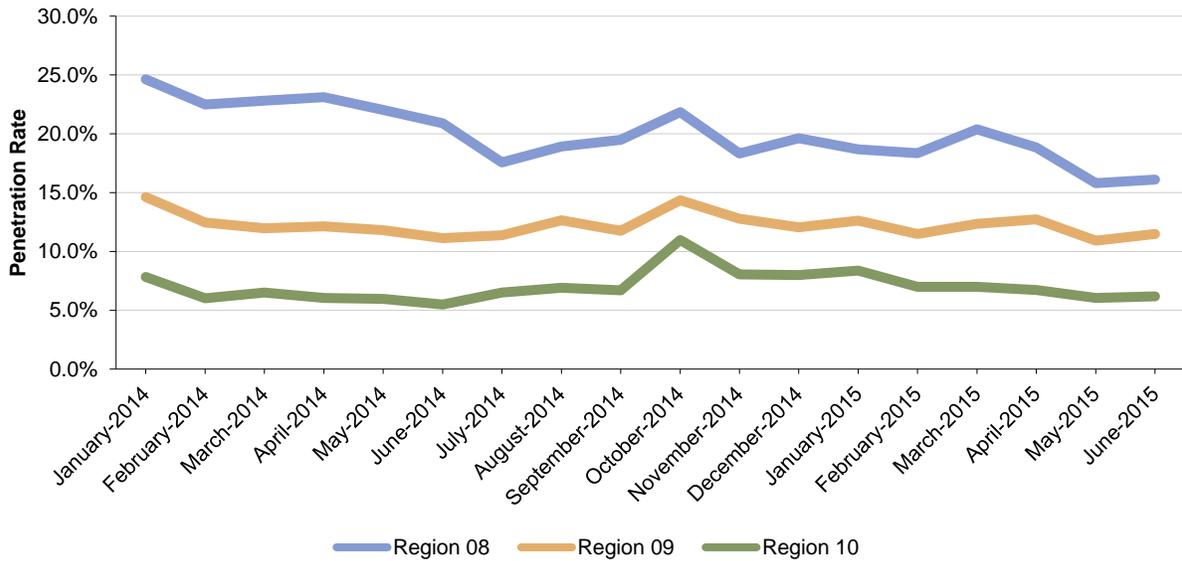


Figure 23 - Primary Care Services penetration rate, HSRs 08, 09, 10

The member and provider count graphs appear to make more sense in the context of the penetration rate which, for Region 08, was almost double that of the other two regions. This might indicate Medicaid members in Region 08 were in poorer health than those in Regions 09 and 10, or perhaps that there were potential access complexities in Regions 09 and 10 that were not present in Region 08.

Analysis for HSRs 08, 09, and 10

Trends were relatively stable for all three regions, with the exception of HSR 08, which experienced a 10% decline in service penetration during the 18 month analysis period. This decrease was more pronounced than the overall decline, however, HSR 8 also experienced a net increase in active providers (seven). Utilization will be closely monitored for signs of an access issue.

When looking at the overall usual source of care (USOC) figures, in 2013, it appears as though 89% of Medicaid members reported having a USOC, while 86% of other insured persons reported having a USOC. And while there was a slight decrease from 2013 to 2015, with Medicaid members reporting a USOC down from 89% to 87%, this decrease was small and does not indicate an access issue.²⁰

As is common in rural communities, there were fewer doctors per patient; this does not indicate an issue with Medicaid member access to primary care that is not also present for health care payers in general.

HSRs 04, 07, and 13

Health Statistic Regions 04, 07, and 13 are comprised of residents in the central to southern part of the State.

A mix of urban and rural communities with some mountainous regions, these HSRs account for approximately 14.6% of the State's overall population.



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Figure 24 - Diagram of HSRs 04, 07, 13

²⁰ Source: CHAS Data, Colorado Health Institute, 2013 and 2015

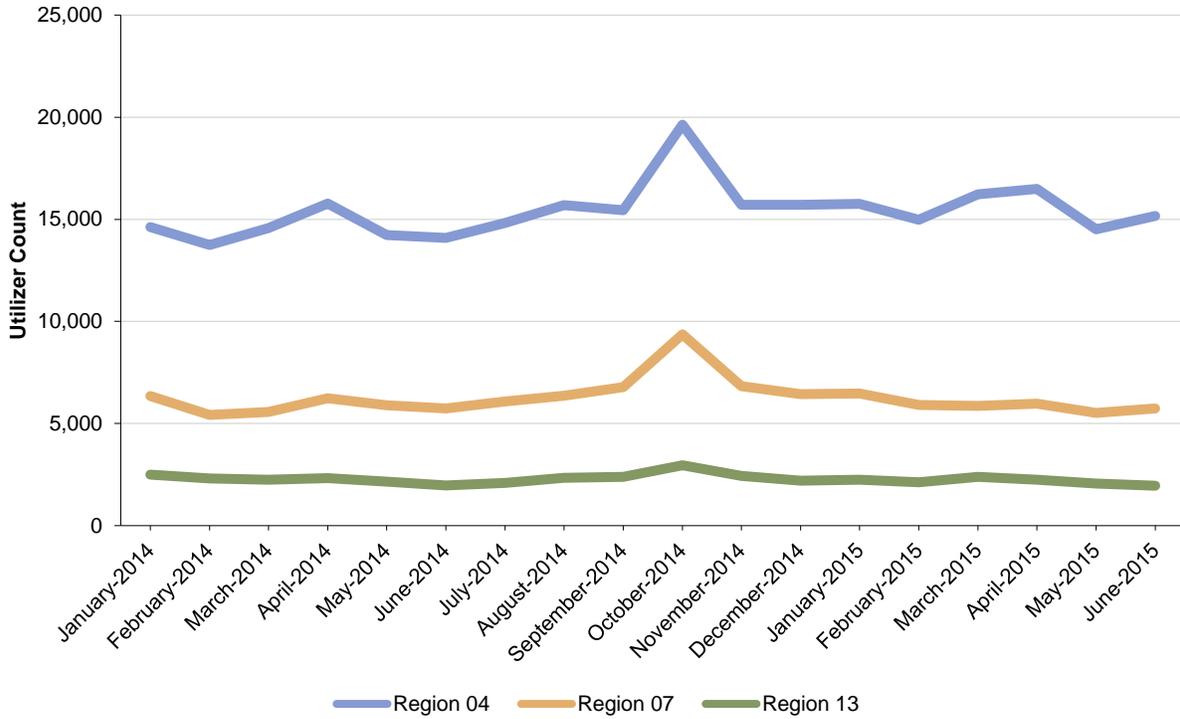


Figure 25 - Primary Care Services utilizer count, HSRs 04, 07, 13

The number of Medicaid members in Region 04 was almost double that of the utilizer counts of Regions 07 and 13 combined.²¹

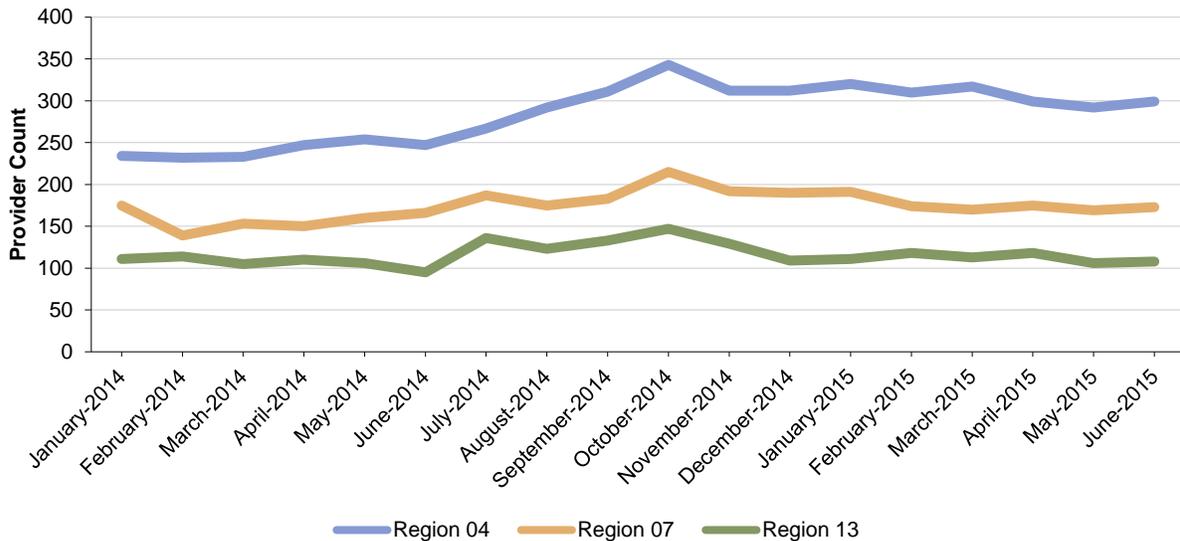


Figure 26 - Primary Care Services provider count, HSRs 04, 07, 13

²¹ Source: CHAS Data, Colorado Health Institute, 2013 and 2015

Accordingly, the number of providers for Region 04 was higher than Regions 07 and 13. As the population of each region increased, from 2014 to 2015, so did the provider count, helping to negate potential access issues in these regions.

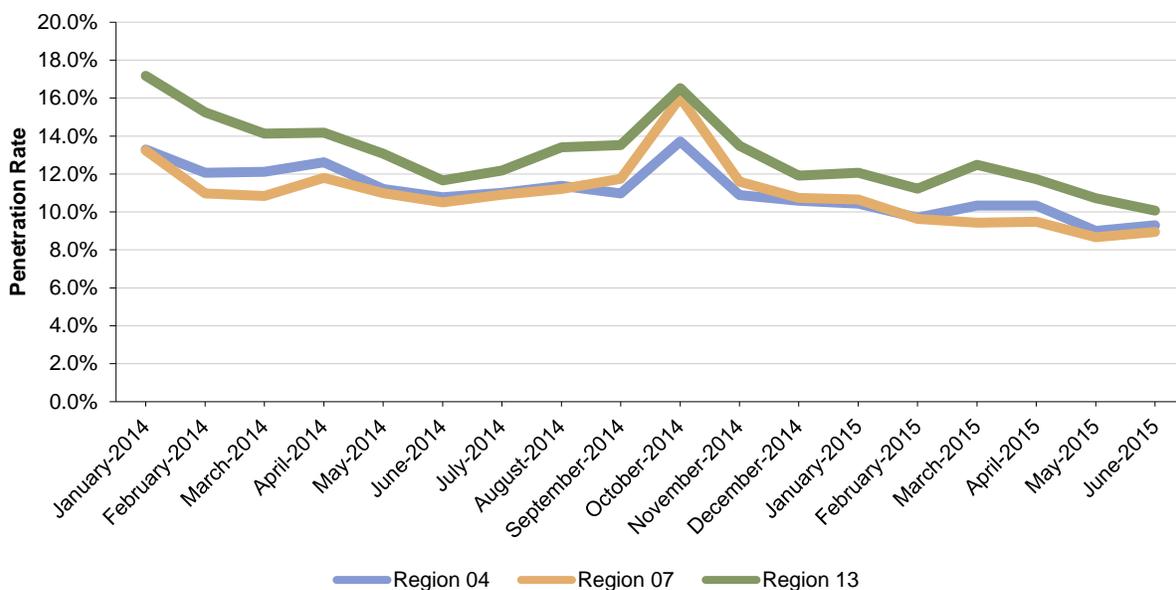


Figure 27 - Primary Care Services penetration rate, HSRs 04, 07, 13

All three regions had similar service penetration rates, though Region 13 trended consistently higher than Regions 04 and 07. As this is a broad, high-level examination of access trends across regions, it is difficult to immediately understand why, despite the high active provider count that the service penetration rate is the lowest. For example, the active provider count of Region 04 was much higher than the other regions, yet the service penetration rate was often lowest. This may imply constraints on access that cannot be understood from claims data alone and may only be investigated at the ground level in the community. This data does not demonstrate trends which signal an access issue.

Analysis for HSRs 04, 07, and 13

In analyzing the data, it would appear that all three HSRs experienced a net decrease in service penetration rate. One factor to look to is the October 2014 spike (present in all primary care HSR penetration rate statistics) which displays cyclical immunization utilization in the fall. HSR 04 saw a net increase of 55 active providers, which is among the largest of any HSR.

Additionally, in 2013, 89% of Medicaid members for these regions reported having a usual source of care (USOC) as compared to 91% of other insured persons.²² While these figures decreased for Medicaid members, from 89% in 2013 to 85% in 2015, this does not indicate an access issue because of the massive influx of newly eligible members under Medicaid expansion who may have gained Medicaid eligibility but who may not have accessed Primary Care Services regularly, which diminishes the overall USOC rate. This is especially true when taking in to account the Medicaid member count increase which occurred from 2013 to 2015, growing more than 6% in that short period of time.

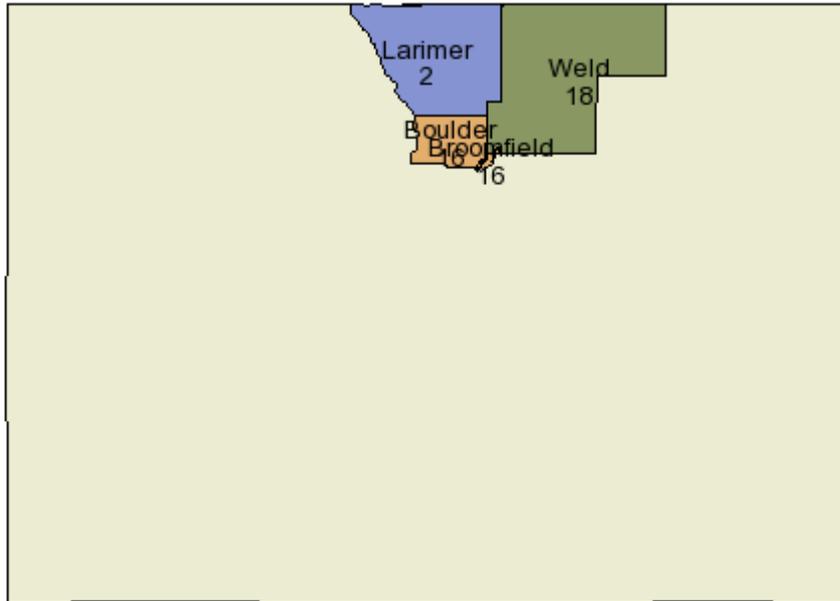
²² Source: CHAS Data, Colorado Health Institute, 2013 and 2015

Due to these factors, it can be asserted that these statistics do not appear to indicate an access issue.

HSRs 02, 16, 18

Health Statistic Regions 02, 16, and 18 are comprised of residents in the central and northern part of the State.

Predominately rural and somewhat mountainous, with numerous urban centers, these HSRs account for approximately 15.1% of the State's overall population.



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Figure 28 - Diagram of HSRs 02, 16, 18

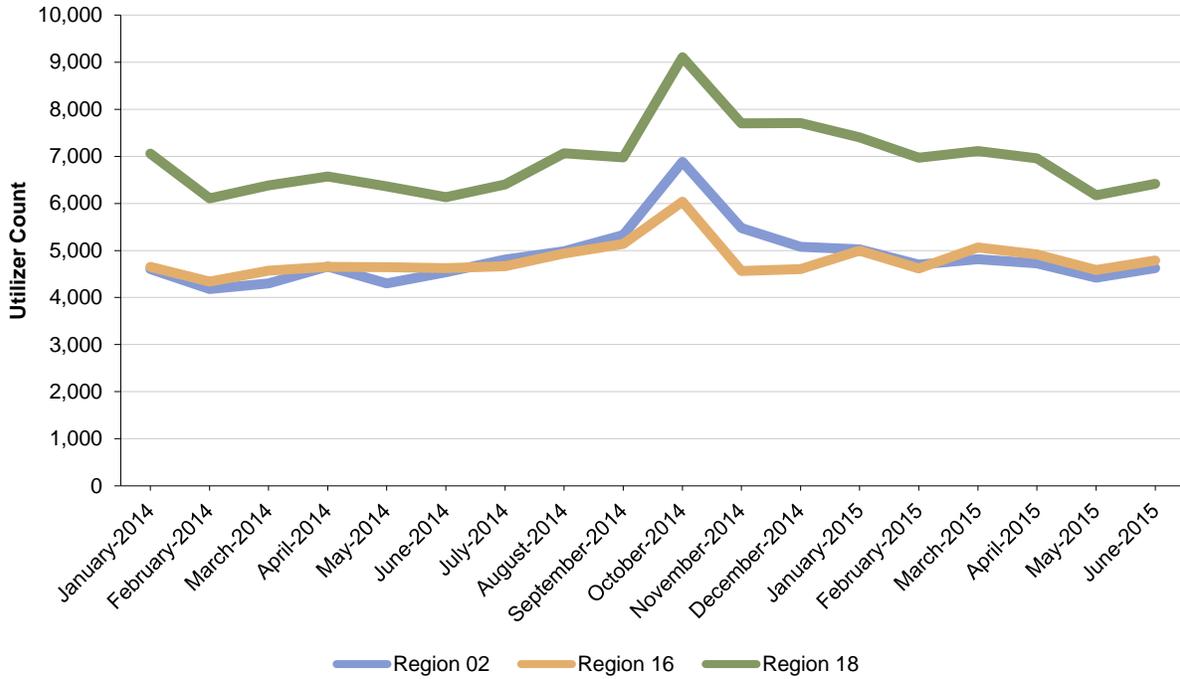


Figure 29 - Primary Care Services utilizer count, HSRs 02, 16, 18

It would appear that the number of utilizers in Region 18 was larger than that of Regions 02 and 16. This could be due in part to the large socioeconomic differences between regions; Region 16 had almost double the median household income than that of Regions 02 and 18.²³

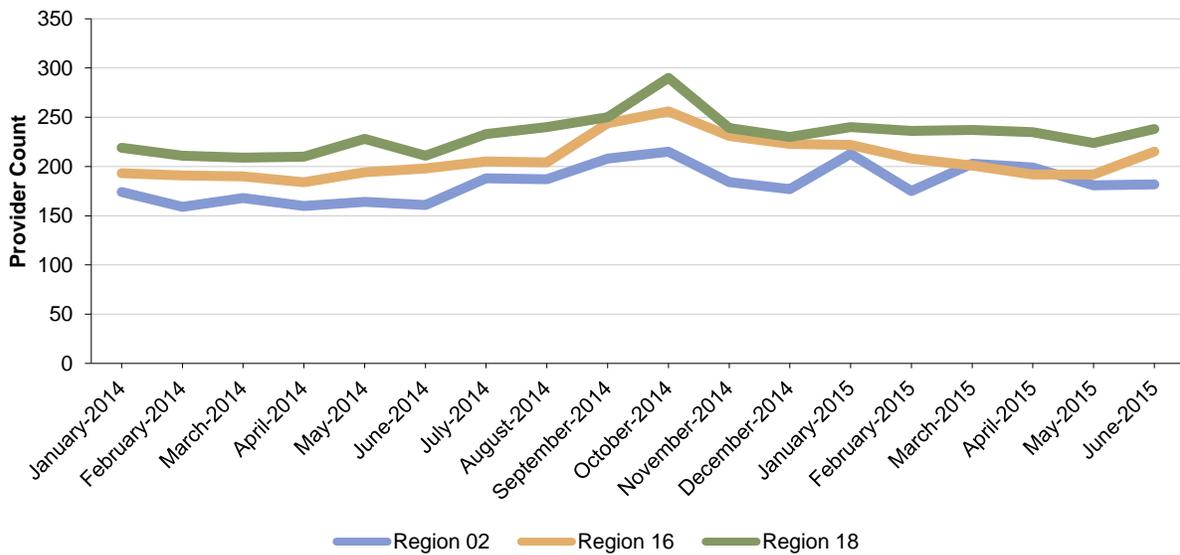


Figure 30 - Primary Care Services provider count, HSRs 02, 16, 18

²³ Source: Colorado Demographics and Census Bureau, 2015

Provider counts for these regions appear relatively stable and even year-over-year.

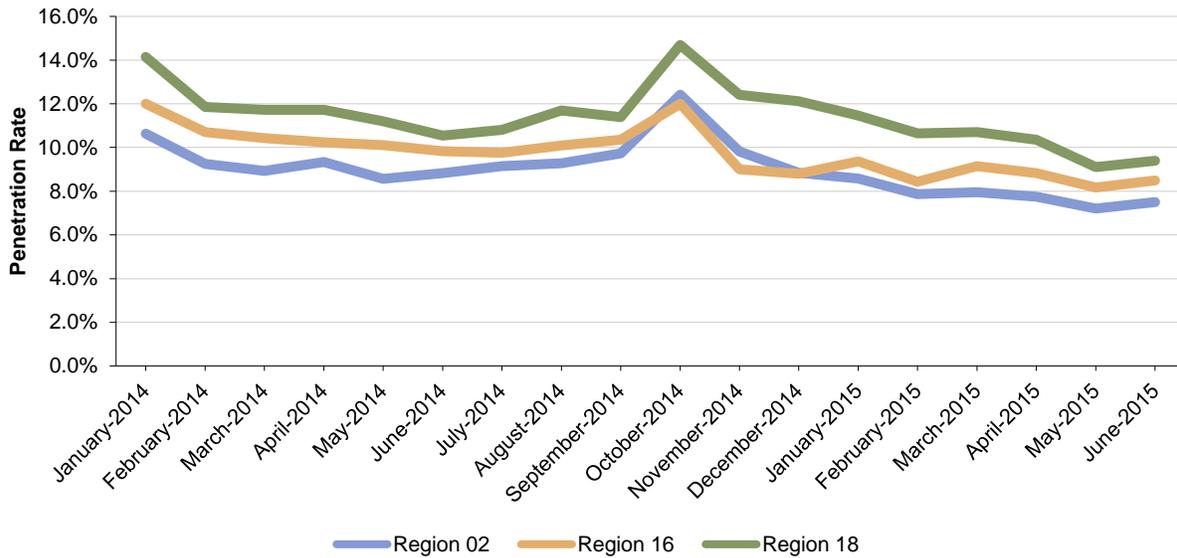


Figure 31 - Primary Care Services penetration rate, HSRs 02, 16, 18

While member counts and active provider counts for all HSRs increased slightly, it appears as though penetration rates fell from 2014 to 2015.

Analysis for HSRs 02, 16, and 18

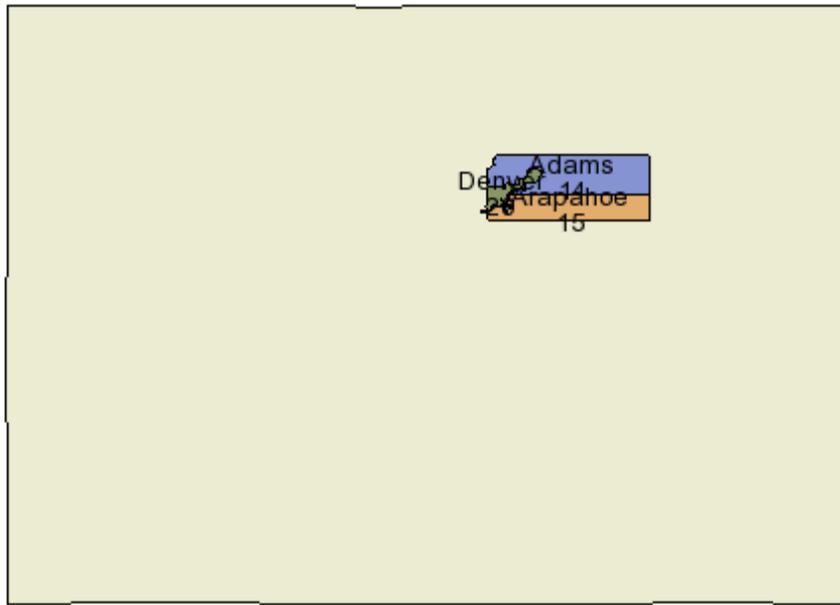
Penetration rates for all three HSRs dropped from their high point in January 2014, likely as a result of Medicaid expansion enrollment increasing the pool of eligible members, who may not utilize services at the same historical rates previously seen.

However, in 2013, 88% of Medicaid members reported having a usual source of care (USOC) which mirrored what insured persons of other types of insurance reported as well. And while we did see a decrease, from 88% in 2013 to 84% in 2015, these statistics do not indicate an access issue.²⁴

HSRs 14, 15, 20

Health Statistic Regions 14, 15, and 20 are comprised of residents in the central part of the State. Predominately urban, these HSRs account for approximately 25.2% of the State's overall population.

²⁴ Source: CHAS Data, Colorado Health Institute, 2013 and 2015



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Figure 32 - Diagram of HSRs 14, 15, 20

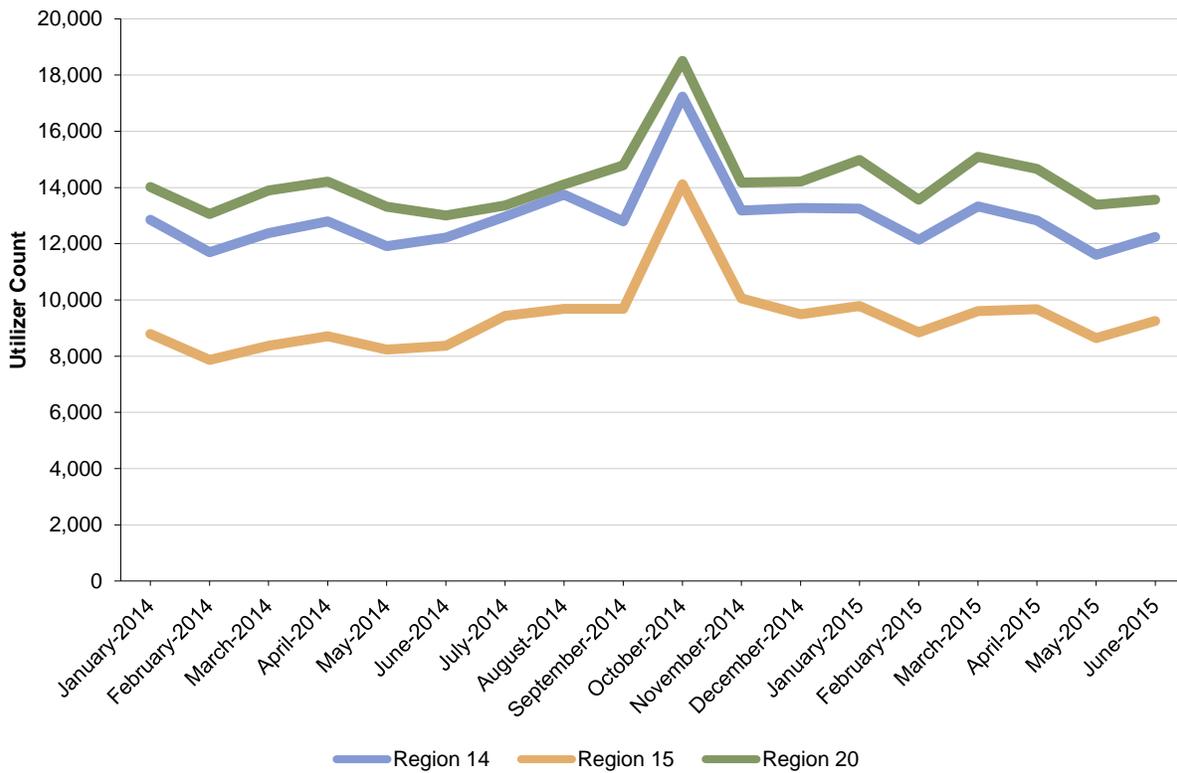


Figure 33 – Primary Care Services utilizer count, HSRs 14, 15, 20

As is logical given the large population of these regions, the utilizer count for Regions 14, 15, and 20 were larger than that of other surrounding regions.

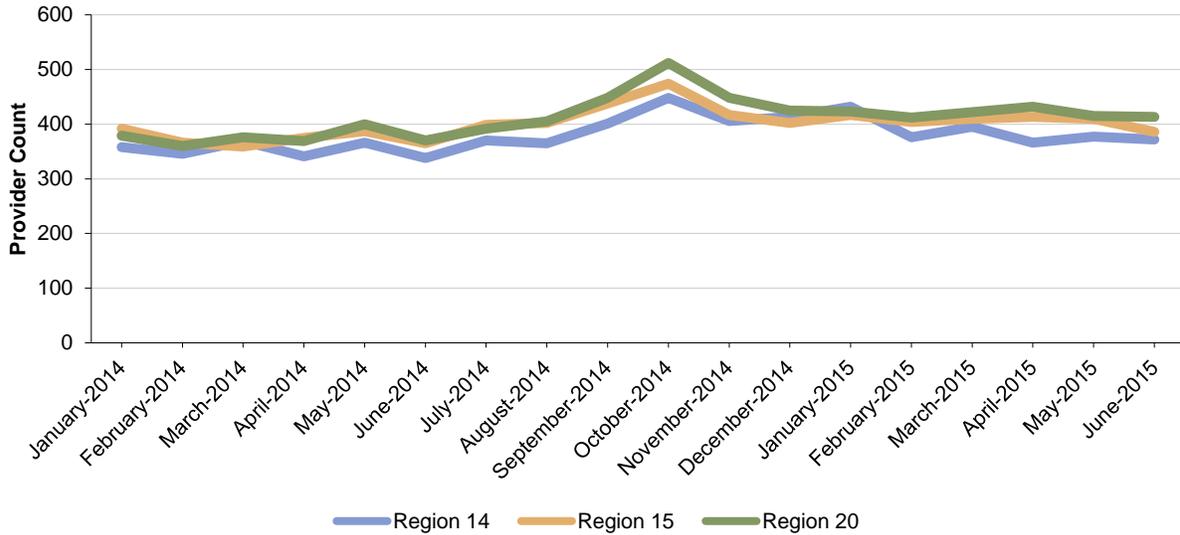


Figure 34 - Primary Care Services provider count, HSRs 14, 15, 20

Similarly, the provider count was also larger than that of other regions, particularly when comparing to more rural and mountainous regions.

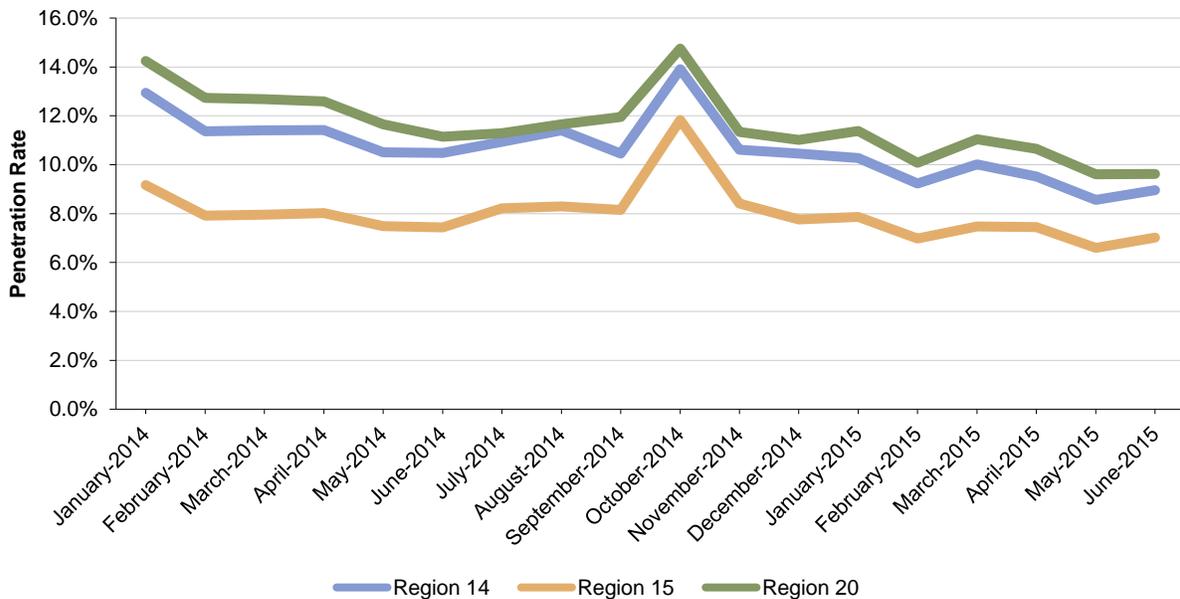


Figure 35 - Primary Care Services penetration rate, HSRs 14, 15, 20

While the member and provider counts appear relatively stable year-over-year, it would appear that there was a small decrease in penetration from 2013 to 2015.

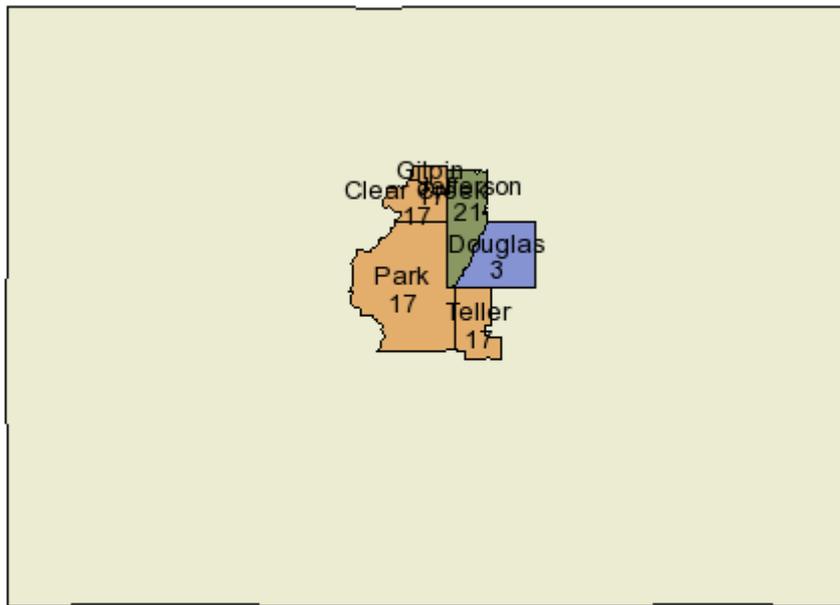
Analysis for HSRs 14, 15, and 20

It can be asserted that these HSRs experienced the same overall trends as others for Primary Care Services: moderate growth in member and provider count; and a slight decrease in penetration rates. Taken together, these trends do not indicate an access issue.

When looking at usual source of care (USOC), 88% of Medicaid members reported having regular doctor visits, as compared to other insured persons, who reported 89%. While these numbers declined, from 89% in 2013 to 88% in 2015, this is not a statistically significant decrease. Particularly, when looking at the large population growth from 2013 to 2015, which grew by approximately 50,000 insured persons.²⁵

HSRs 03, 17, 21

Health Statistic Regions 03, 17, and 21 are comprised of residents in the central part of the State. A mix of urban and rural geography, these HSRs account for approximately 16% of the State's overall population.



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Figure 36 - Diagram of HSRs 03, 17, 21

²⁵ Source: CHAS Data, Colorado Health Institute, 2013 and 2015

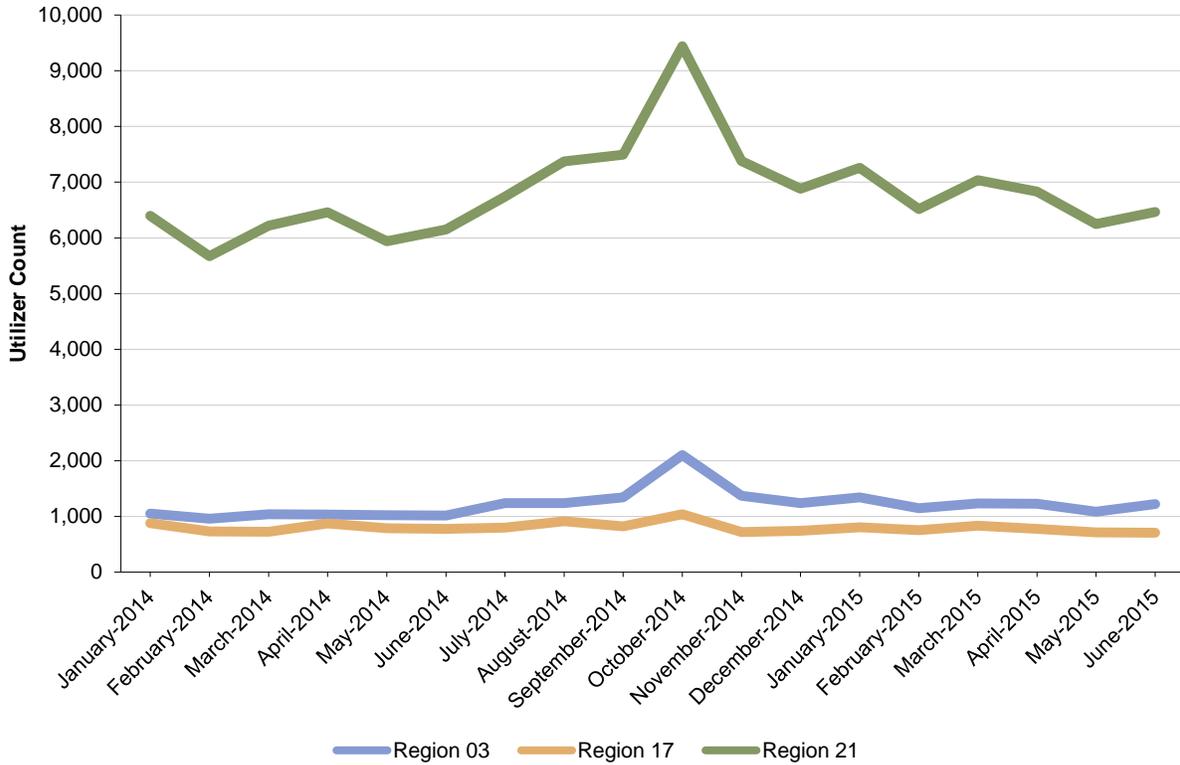


Figure 37 - Primary Care Services utilizer count, HSRs 03, 17, 21

Utilizer count for these regions varied greatly. Region 21, a large suburb of Denver, had larger numbers of Medicaid members. This makes sense, as the number of insured persons in Region 21 was almost double that of Region 03, and almost nine times that of Region 17.²⁶

²⁶ Source: CHAS Data, Colorado Health Institute, 2013 and 2015

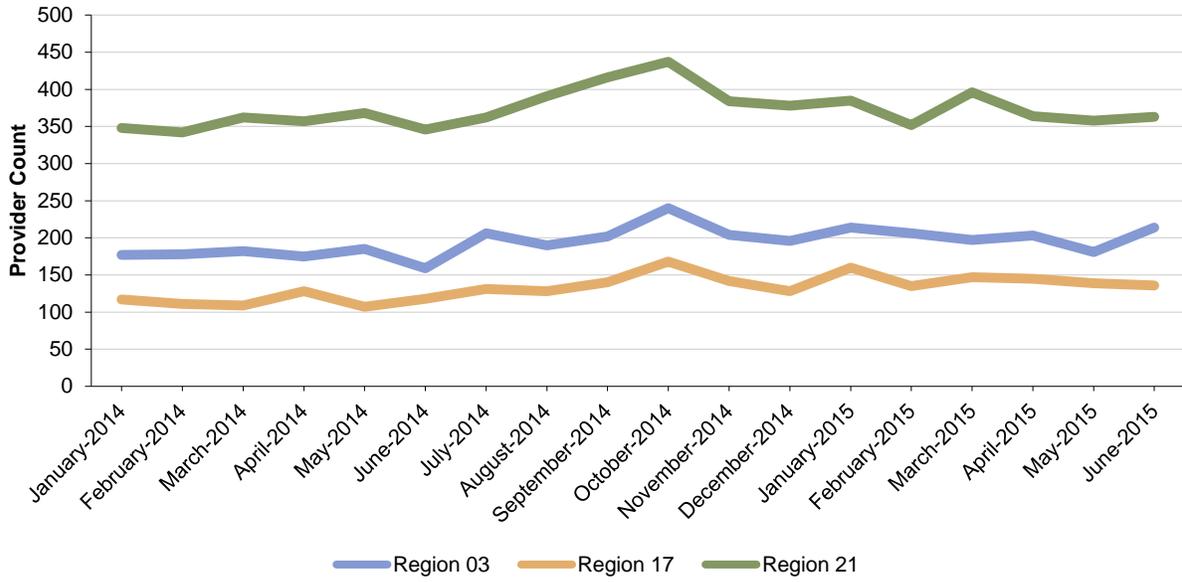


Figure 38 - Primary Care Services provider count, HSRs 03, 17, 21

It would make sense that the provider count was higher in Regions 21 and 03, with numbers remaining relatively stable from 2013 to 2015.

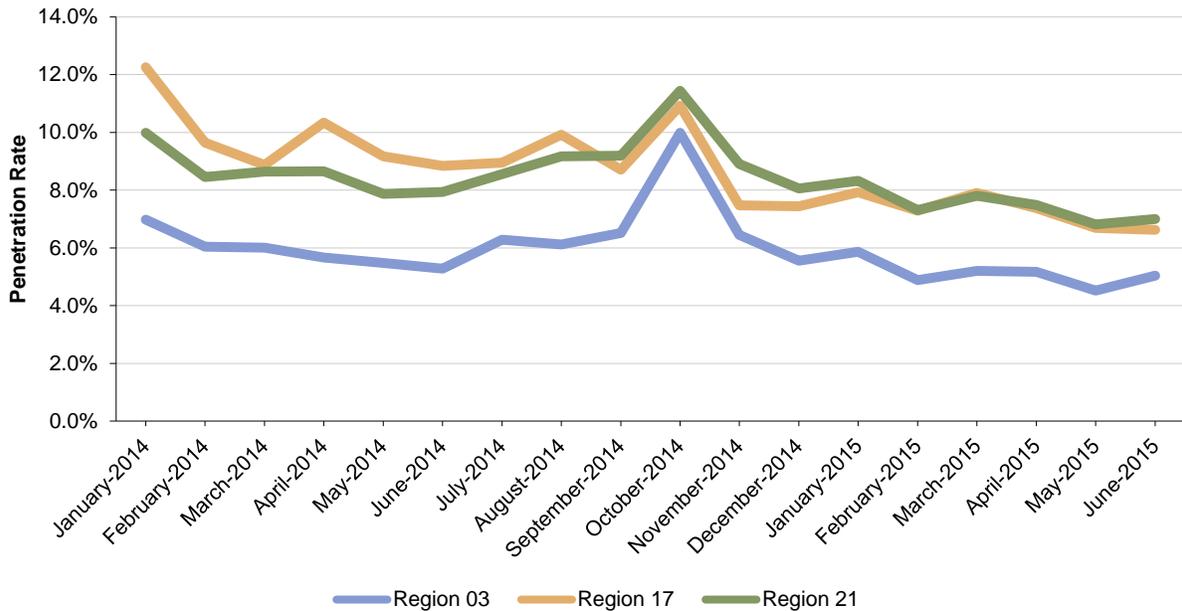


Figure 39 - Primary Care Services penetration rate, HSRs 03, 17, 21

As we see in other regions, there appears to have been a slight decrease in penetration rates for these regions year-over-year.

Analysis for HSRs 03, 17, 21

While 94% of Medicaid members reported having a usual source of care in 2013, that figure dropped to 84% in 2015.²⁷ However, we assert that these HSRs experienced the same overall trends as others for Primary Care Services: moderate growth in member and provider count; and a slight decrease in penetration rates.

²⁷ Source: CHAS Data, Colorado Health Institute, 2013 and 2015

Primary Care Services Analysis by Provider Type and Place of Service

Figures 40 and 41 are a FY 2014-15 snapshot of Billing Provider type by utilizer count. They depict the distribution of billing provider types who deliver the benefit, within the service category. *Fulfills requirement 42 CFR 447.203(b)(1)(ii)*

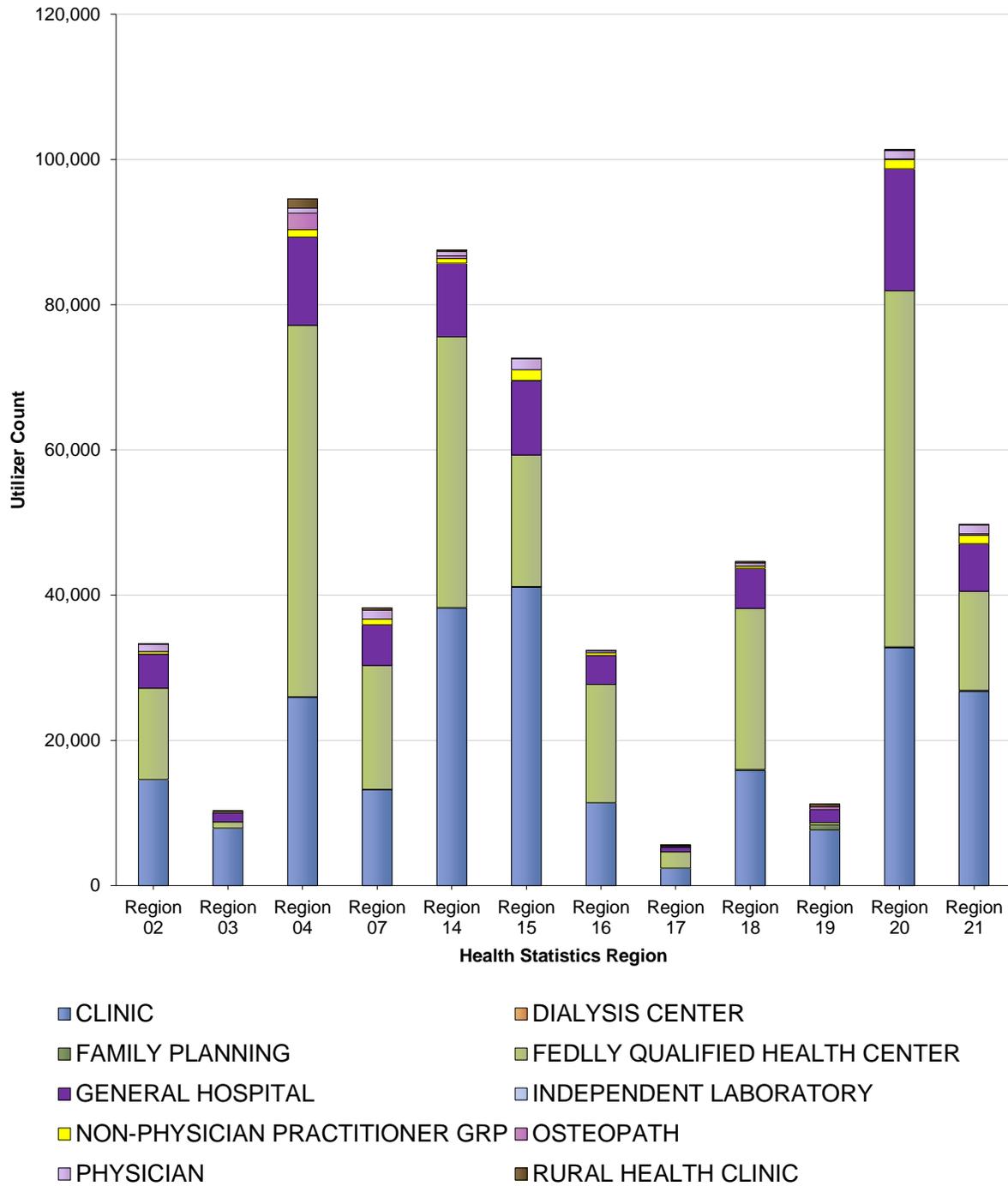


Figure 40 - Primary Care Services provider type by urban HSRs

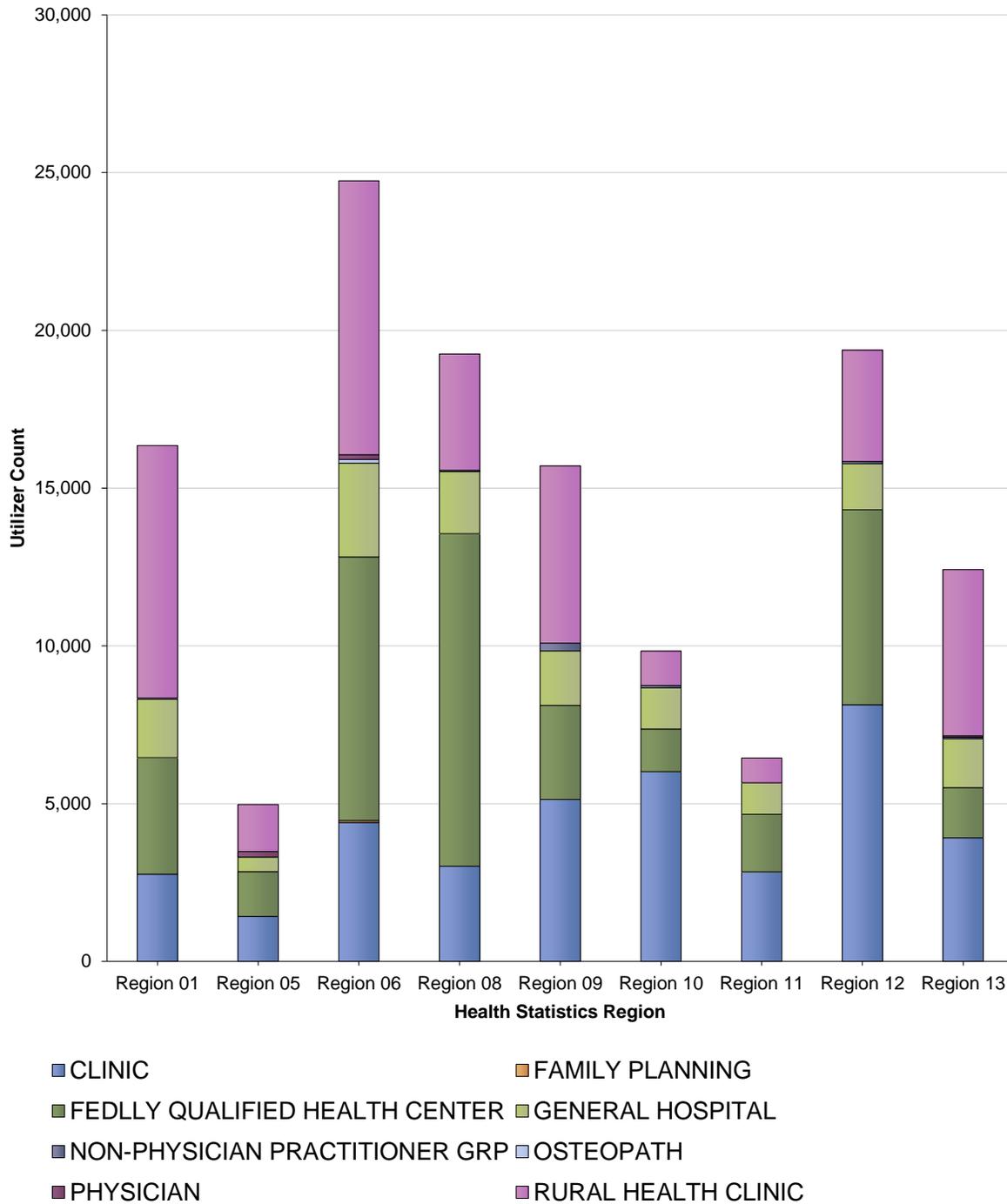


Figure 41 - Primary Care Services provider type by rural HSRs

Analysis of Provider Type of Utilizer Count

Federally Qualified Health Centers provide Primary Care Services in both rural and urban settings. Rural Health Clinics, as expected, provided a higher share of care in rural areas. While this data showed who was providing services proportionately, by region, it does not by itself demonstrate sufficient nor

insufficient access to care. However, combined with the previous statistics detailing the service penetration rates for each HSR, this statistic does not indicate an access issue.

Figures 42 and 43 are a FY 2014-15 snapshot of Place of Service by utilizer count. They depict the distribution of place of service (the setting where the benefit was delivered) within the service category. *Fulfills requirement 42 CFR 447.203(b)(1)(ii)*

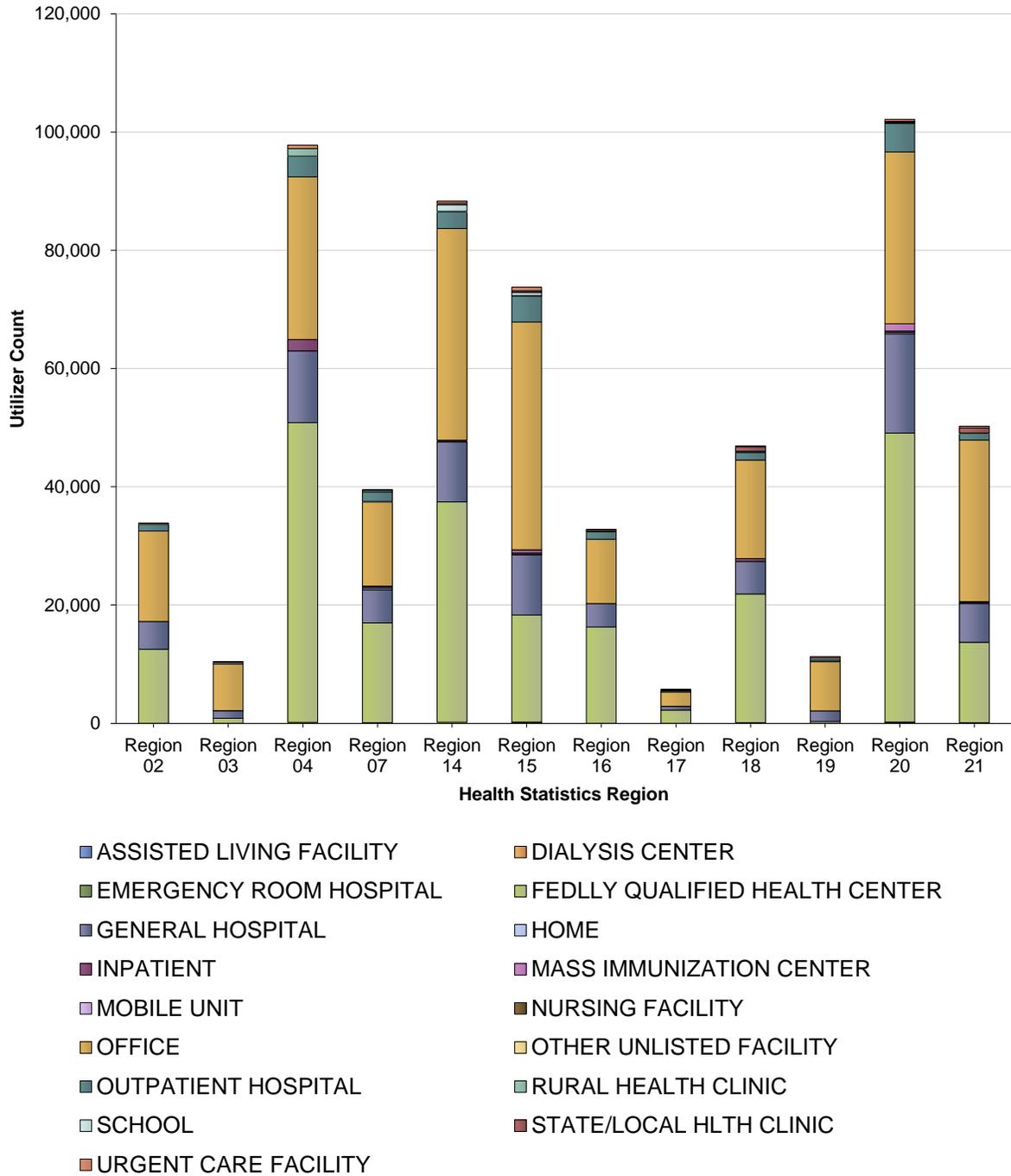


Figure 42 – Primary Care Services place of service by urban HSRs

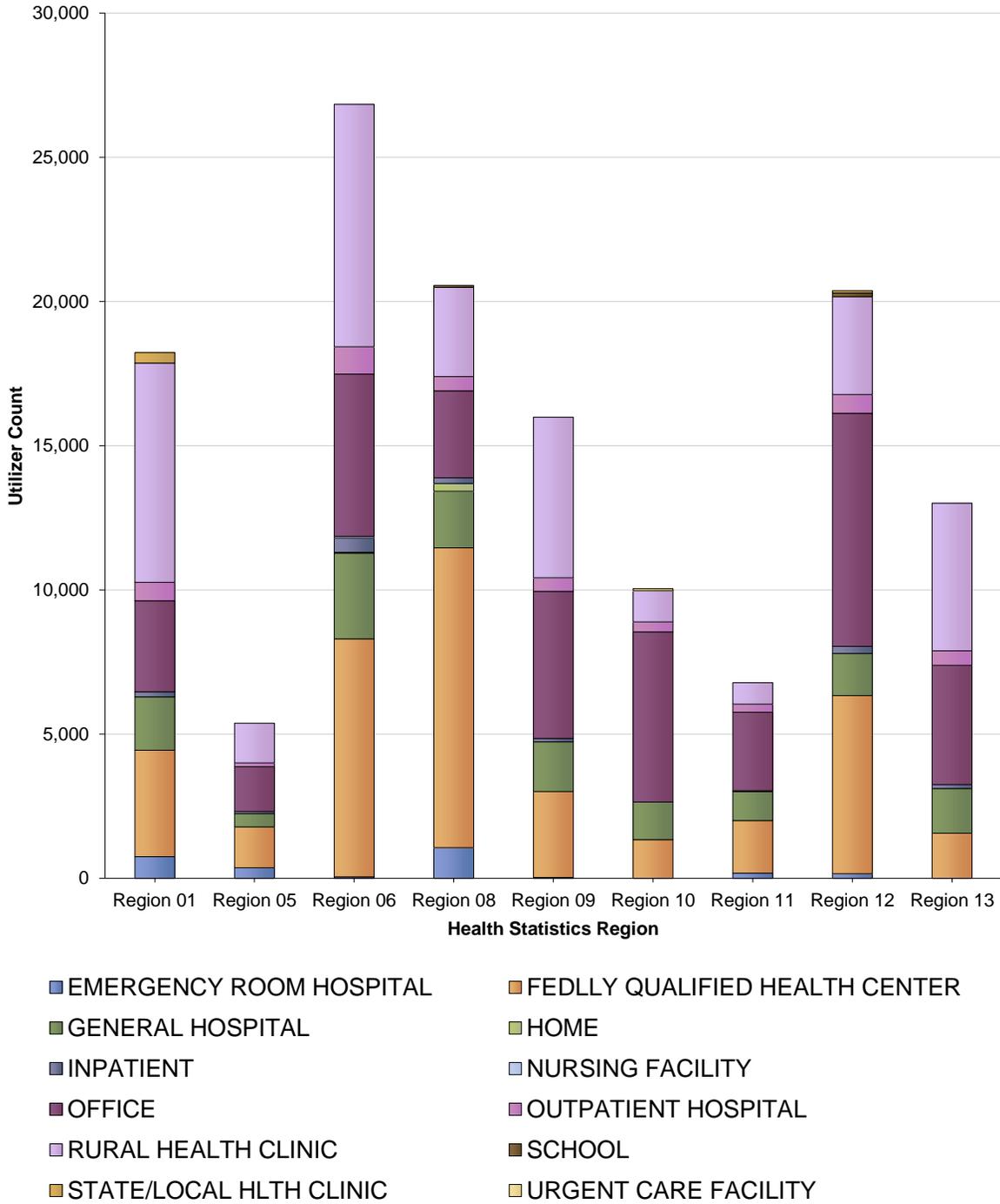


Figure 43 – Primary Care Services place of service by rural HSRs

Analysis of Place of Service by Utilizer Count

The most common places of service were Office, Rural Health Clinic, General Hospital, and Federally Qualified Health Center. All other places appeared in claims data very infrequently. While this data showed where services are being provided proportionately, by HSR, it does not, by itself, demonstrate

sufficient or insufficient access to care. However, combined with the previous statistics detailing the service penetration rates for each HSR, this statistic does not indicate an access issue.

Primary Care Services Colorado Health Access Survey Data

The following metrics From the Colorado Health Access Survey were used to further investigate access to care.

Visited a health care professional

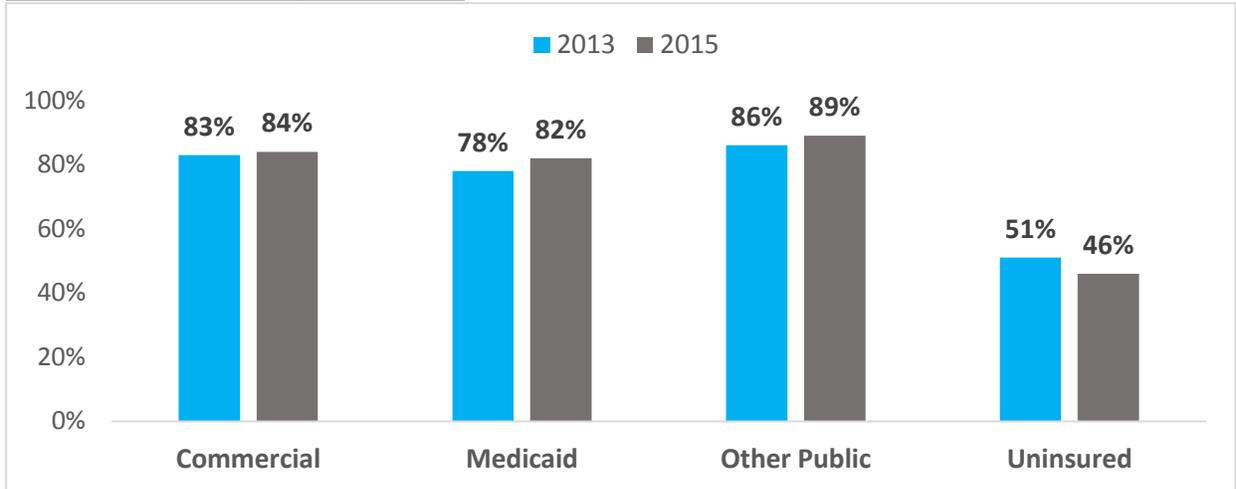


Figure 44 - Primary Care Services percentage of participants who visited a health care professional, by coverage

Analysis for: 'Visited a health care professional'

The percentage of Medicaid members surveyed who visited a health care professional increased from 2013 to 2015, but this difference was not statistically significant. In both 2013 and 2015, Medicaid members were not significantly more or less likely to have visited a health care professional than other commercially and other public insured Coloradans combined. This shows that access to care, in very general terms, was comparable between Medicaid and other payers.

Had a preventive care visit

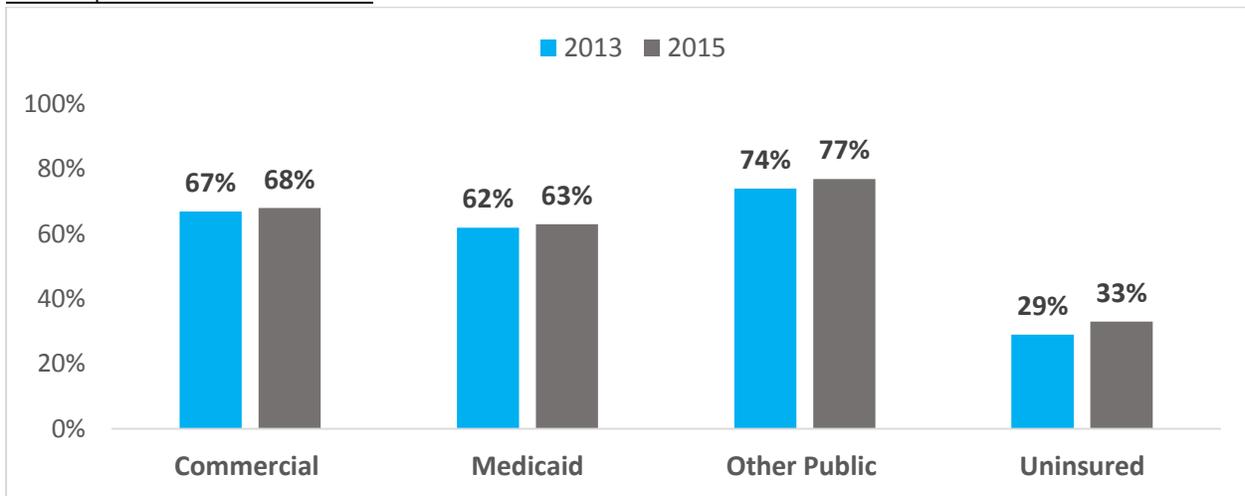


Figure 45 - Primary Care Services percentage of participants who had a preventive care visit, by coverage

Analysis for: 'Had a preventive care visit'

In regards to preventive care visits, survey data demonstrated that, while the amount of visits to a preventive care provider increased for Medicaid members from 2013 to 2015, in general, members of other insurance types were more likely to have preventive care visits overall. However, the number of visits to a healthcare professional (as indicated in Figure 44) showed no statistically significant percentage change from 2013 to 2015. Additionally, Medicaid members were not significantly more or less likely to have visited a health care professional compared to those enrolled in other types of insurance. It is difficult to disentangle the socioeconomic factors that may influence a member's choice or ability to seek preventive care visits from the member's access to those preventive care visits. This data suggests that the trend towards more preventive care access for Medicaid members is stable and may be improving.

Last ER visit was for non-emergency

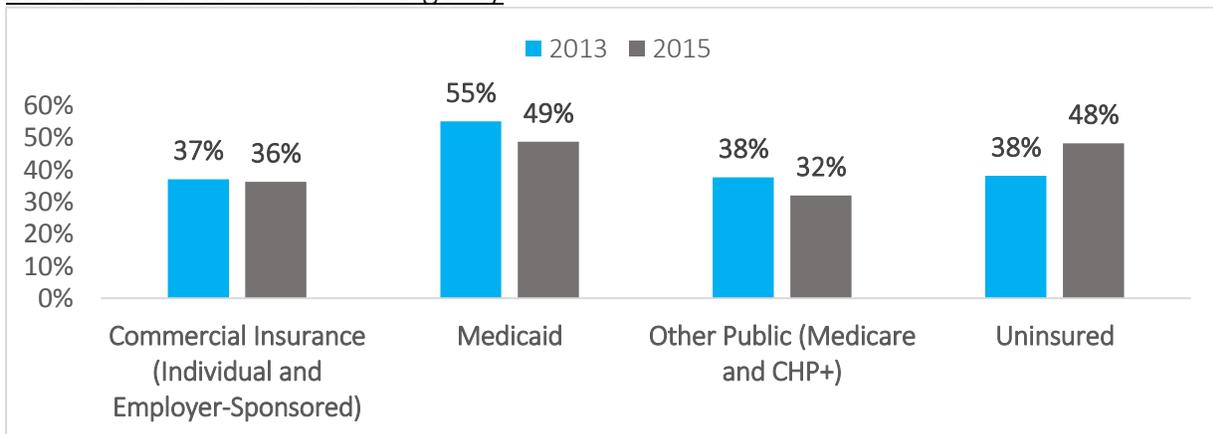


Figure 46 - Primary Care Services percentage of participants whose last ER visit was non-emergency, by coverage

Analysis for: 'Last ER visit was for non-emergency'

The percentage of Medicaid members surveyed who said their last emergency room visit was for a non-emergency declined from 2013 to 2015; this difference is not statistically significant. In 2015, Medicaid members were still significantly more likely to go to an ER for a non-emergency than other insured Coloradans. This is a trend we also see nationally and may be attributable to several factors that are not related to access, such as cultural mistrust of the health care system at large, which might affect an individual's decision to seek routine services.

Went to ER due to convenience

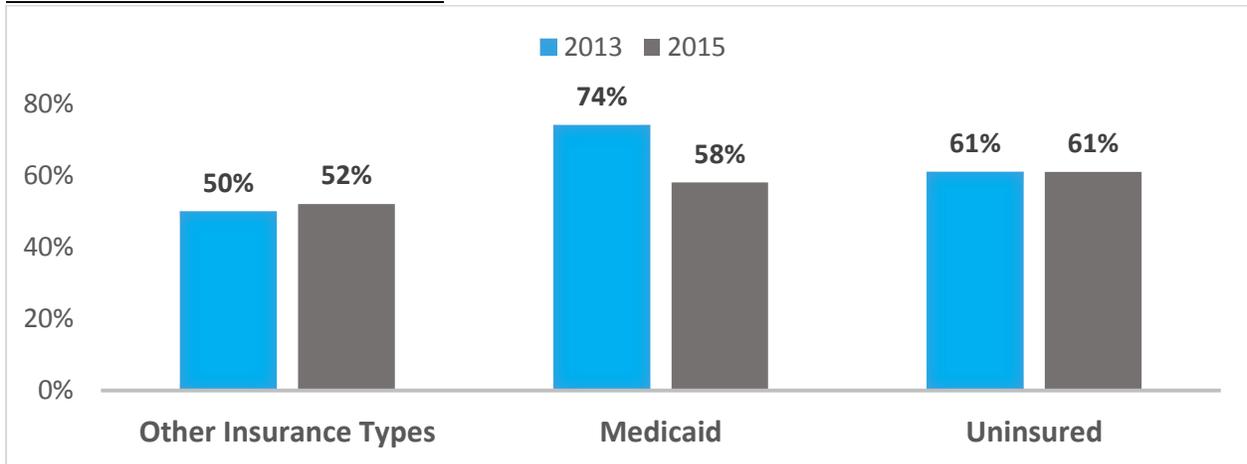


Figure 47 - Primary Care Services percentage of participants who went to ER for convenience, by coverage

Analysis for: 'Went to ER due to convenience'

Of all Medicaid members surveyed who went to the ER for a non-emergency, the percentage who responded that "it was more convenient to go to the hospital emergency room" dropped by 16% from 2013 to 2015. This is a statistically significant change. In 2015, Medicaid members were not significantly more or less likely to go to the ER out of convenience than other insured Coloradans.

Told doctor was not accepting new patients

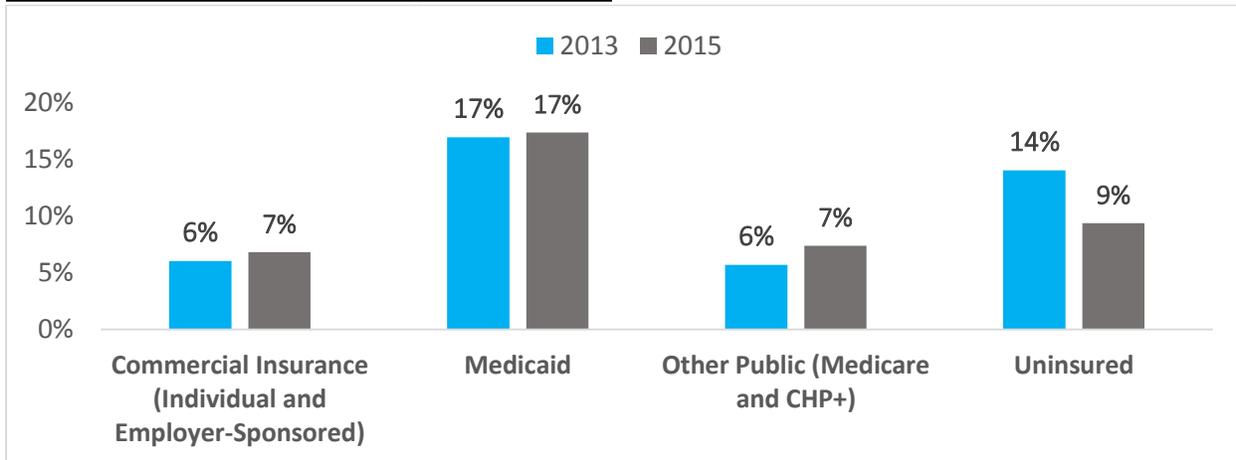


Figure 48 - Primary Care Services percentage of participants who were told a doctor wasn't accepting new patients, by coverage

Analysis for: 'Told doctor was not accepting new patients'

The percentage of Medicaid members surveyed who said they were told by a doctor's office that they weren't accepting new patients did not change from 2013 to 2015. In 2015, Medicaid members were more likely to be told a provider was not accepting new patients than other insured Coloradans; this is a statistically significant difference. This data suggests that Medicaid expansion did not affect provider's willingness or ability to accept Medicaid members. Survey results suggest providers were much more likely to accept a new commercially insured member than a Medicaid member. This statistic alone does not indicate an access issue. It may indicate that Medicaid members must place additional calls before locating a provider that accepts new Medicaid patients.

Claims utilization data showed that, in most HSRs, the number of total utilizers increased over time, as did the number of active billing providers. This suggests that, even though 17% of respondents to the CHAS stated their doctor was not accepting new patients, they were still able to access Primary Care Services in growing numbers. The provider counts increased; doctors were either newly enrolling in Health First Colorado or once again serving Medicaid members in renewed numbers.

Potential Access issues

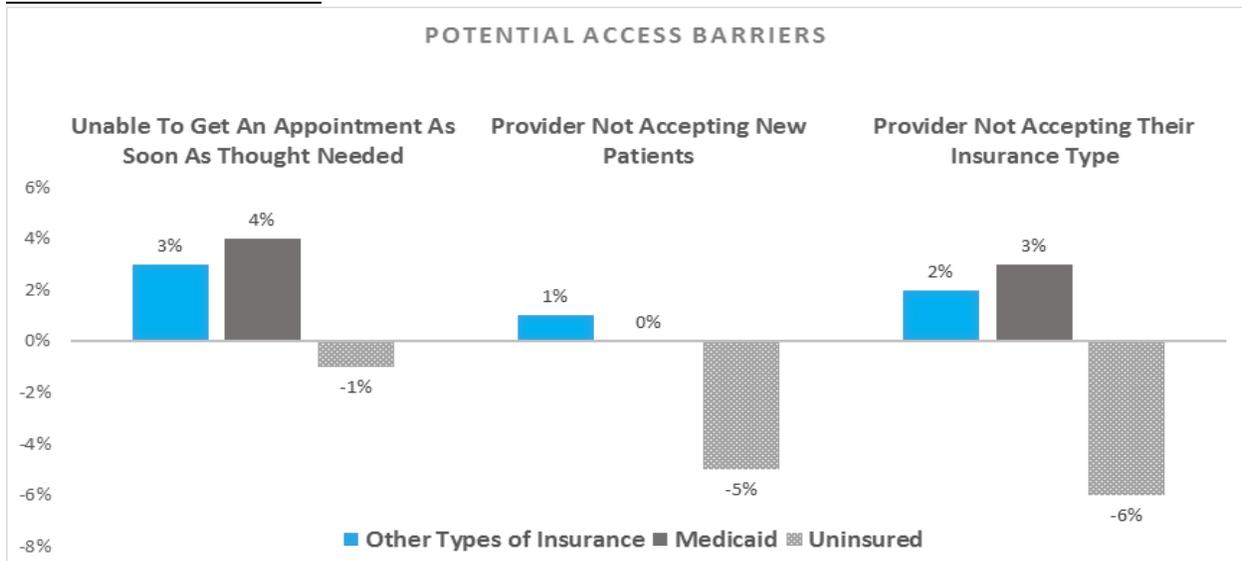


Figure 49 - Primary Care Services percentage of participants who said they experienced access issues, by coverage

Analysis for: 'Potential access issues'

Medicaid members surveyed reported more difficulty getting appointments, finding providers who accept new patients, and who accept Medicaid members. These figures are statistically significant. These figures indicate that, in general, Medicaid members may be experiencing a higher percentage of difficulty year-over-year, compared to those receiving other types of insurance. These figures do not indicate whether members surveyed were ultimately able to find a provider who accepts new Medicaid patients, and must be evaluated in the context of all data gathered.

Where there are access issues to receiving adequate Primary Care Services, data typically shows that Medicaid members opt to visit the ER to seek care. However, data from the same CHAS survey suggests that the percentage of Medicaid members who went to the ER for a non-emergency decreased significantly from 2013 to 2015, a potential indicator of access improvement.

Primary Care Services Rate Comparison – Actual or Estimated Levels of Provider Payment

Fulfills requirement 42 CFR 447.203(b)(1)(v)

In aggregate, 2016 Health First Colorado rates for Primary Care Services varied by place of service based on the top 50 procedure codes used to bill for services. Of the top 50 codes, the Department identified at least 10 Medicaid and private payer codes in the CIHVC data (from the Colorado All Payer Claims Database) that matched and could be used for comparative analysis. Available Medicare codes do not differentiate by place of service, therefore the average of all top codes for all places of service was used for comparative analysis. This table displays the percentage Medicaid rates differ from private payers (CIVHC difference) and Medicare. For example, Medicaid rates are 7.02% below Medicare. The wide difference in CIVHC rate percentages below reflects the different codes that were both available and were most commonly used. Each place of service had different commonly used codes available.

Place of Service	CIVHC % difference	Medicare % difference
Office	-26.46%	-7.02%
Urgent care facility	-4.03%	-7.02%
Rural health clinic	3.70%	-7.02%
Ambulatory surgical center	8.04%	-7.02%
Other place of service	-28.30%	-7.02%
Outpatient hospital	22.18%	-7.02%
Emergency room -- hospital	-5.65%	-7.02%
Community mental health center	23.79%	-7.02%
Public health clinic	121.80%	-7.02%
Mass immunization center	-0.41%	-7.02%
Mobile unit	Not Available	-7.02%
Home	64.28%	-7.02%

Table 5 - Primary Care Services rate comparison table

Primary Care Services Input from Beneficiaries, Providers, and Stakeholders

Fulfills requirement 42 CFR 447.204(a)(2)

Fulfills requirement 42 CFR 447.204(b)(3) – as applicable under ‘Specific Analysis of Input from Stakeholders Affected by a Payment Restructure or Reduction’

Primary Care Services Direct-to-Staff Input

Department staff occasionally receive unsolicited input directly from beneficiaries, providers, and stakeholders concerning access to care for this service while performing their operational duties. Staff address and catalogue those access comments in accordance with the procedures detailed in the Access Monitoring Review Plan – Appendix A.

Another mechanism used to track stakeholder feedback, and potential access issues, is our Customer Contact Center (CCC), which documents and reports data for each member interaction. Based on data found within the 2015 CCC reports, staff are able to identify HSRs which have a higher volume of complaints that are - or could potentially be - access related complaints, and work to identify an access issue, or potential barriers to care.

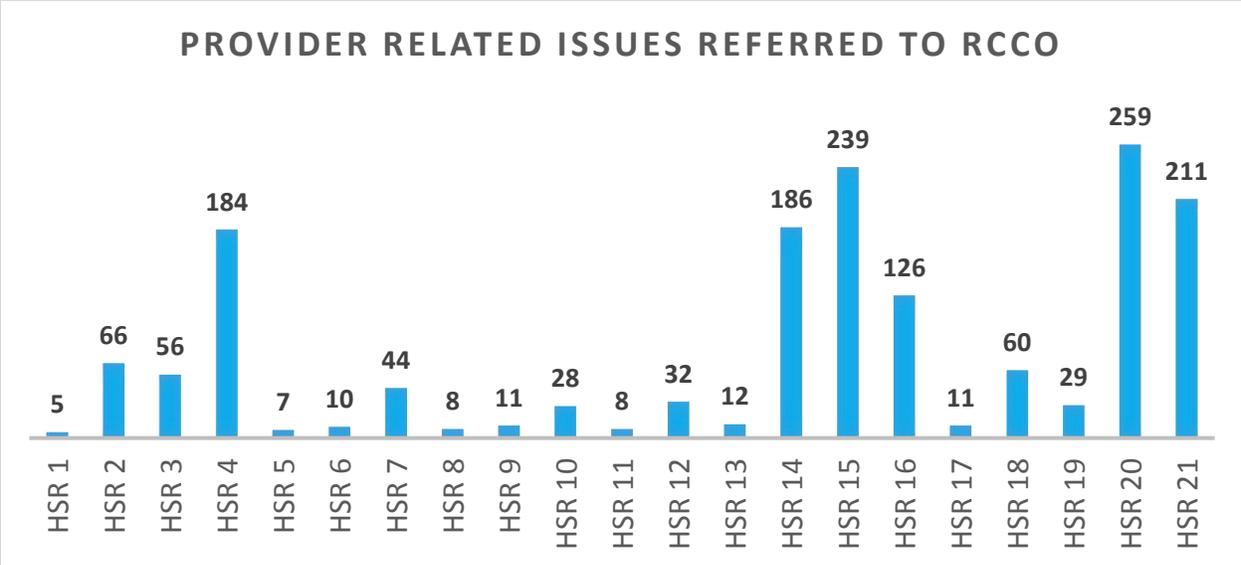


Figure 50 - Primary Care Services referrals to the RCCO for provider calls; 2015

The five HSRs reporting the highest volume of provider complaints in 2015 included: HSR 4, El Paso County; HSR 14, Adams County; HSR 15, Arapahoe County; HSR 20, Denver County; and HSR 21, Jefferson County.

Of the 1,592 provider complaints received in 2015, 68% of them were within these five HSRs. While there have been a larger volume of provider complaints from these five HSRs, they also comprise more than 56% of the entire Health First Colorado population. Additionally, these five HSRs reported an increase in the percentage of members who visited a healthcare professional in the last 12 months, up from 76% in 2013, to 82% in 2015.²⁸

There were no concerns with access to primary care reported to the Primary Care Services benefit manager from July 2015 through March 2016. Nor did the RCCOs contact the benefit manager with concerns about access to primary care.

Primary Care Targeted Stakeholder Input and Input from General Public Notice

A draft of this Plan was sent to key stakeholders and was made publically available on the Department’s website for 30 day public comment. Feedback and input was accepted through email and through an online survey and is summarized in Appendix K. Several stakeholders pointed to anomalies in the way the data and analysis above was originally presented. Where applicable, the Department has clarified. One stakeholder group asserted that Individuals with disabilities experience access issues to Primary Care Services that are not represented in the data, particularly in some parts of the State, such as the Western Slope, where some primary care providers screen out patients with disabilities. The Department is aware of some of these screening practices in the community and we are using all tools

²⁸Source: Colorado Health Access Survey Data

at our disposal, including working with our Regional Care Collaborative Organizations, to ensure Medicaid member access.

Primary Care Services Access Issues Discovered As a Result of This Review

Fulfills requirements 42 CFR 447.203(b)(4)

This is a list of the Access Issues identified using the data available in this review. Data which suggests an Access Issue will be investigated and monitored for a period of two consecutive quarters to ensure the pattern is not an artifact or data anomaly. If investigation does reveal a deficit, the Access Issue becomes an Access Deficiency, which triggers the process described in the Access Monitoring Review Plan – Appendix B (42 CFR 447.203(b)(8)).

No access issues were identified as a result of this review, however a trend in HSR 8 warrants further investigation and will be monitored closely in the next few years. Region 08's penetration rate dropped by 10% during the 18 month analysis period while the provider count increased. This region will be investigated further and reported on in the next version of the Plan.

Primary Care Extent to Which Beneficiary Needs Are Fully Met

Fulfills requirements 42 CFR 447.203(b)(1)(i)

Members were able to access services, such as immunizations and general examinations, as expected. Both the number of primary care utilizers and active providers were on the rise in most HSRs. Service penetration rates fell from January through May 2014 in most HSRs, however, it is believed this is due to the increase in eligible members resulting from Medicaid expansion, who may not utilize services at the same historical rates previously seen.

While the CHAS data indicated that 17% of Medicaid members surveyed were told, when placing a call to the doctor's office, the doctor they contacted was not accepting new Medicaid patients, it was silent on whether those same members were able to access services, for example, when placing a second call. The CHAS data showed that rates of visiting a health care professional, in general, were on par between Medicaid and other commercial insurers. This suggests that care needs are, in fact, being met.

Stakeholders shared anecdotal reports of access concerns for members with disabilities in certain regions of the State. The Department is working with our RCCO partners to investigate and address these concerns and will monitor access closely. The number of provider complaints received by the Department regarding access to Primary Care Services was low and proportional to the size of each region.

Further data gathering will be conducted in the coming years to establish access sufficiency in greater detail. The data available does not indicate that acute access issues are present and the Department believes access is sufficient to meet the needs of the population.

The Department's analytical conclusion is that Primary Care Services are sufficient to enlist enough providers so that services are available at least to the extent they are available to the general population in each geographic area, pursuant to section 1902(a)(30)(A) of the Social Security Act.

Appendix G: Access Monitoring Analysis - Physician Specialist Services

Fulfills requirement 42 CFR 447.203(b)(5)(ii)(B)

Physician Specialist Services Definition of Service

Health First Colorado covers specialty services delivered by an enrolled licensed provider, when determined medically necessary, in a clinic, providers' office, an ambulatory surgery center, outpatient hospital department, or inpatient hospital department. While primary care providers deliver preventive and comprehensive care to a Medicaid member, specialty services often involve treatment for a specific condition, chronic illness, or acute event. The majority of specialty service utilizers are referred via their primary care provider. The Department classifies Physician Specialist Services as those delivered by: specialty physicians (cardiologists, surgeons, urologists, neurologists, radiologists, anesthesiologists); podiatrists; imaging facilities; independent laboratories; and non-physician practitioners.

Physician Specialist Services Characteristics of the Beneficiary Population

Fulfills requirements 42 CFR 447.203(b)(1)(iv)

All Medicaid members have access to the same benefits and the same benefit limitations. All physicians and independent physician practices (clinics) are reimbursed on the fixed fee scheduled. There is no payment variability based on geographic location or population. Utilizers of physician specialty services are mostly female adults between the ages of 21 and 64.

Physician Specialist Services Administrative Claims Utilization Data

Figure 51 is a FY 2014-15 snapshot of demographic groups (children/adults/individuals with disabilities) by utilizer count. This depicts the demographic group distribution of service utilizers, which informs the Beneficiary Characteristic description. *Fulfills requirement 42 CFR 447.203(b)(1)(iv)*

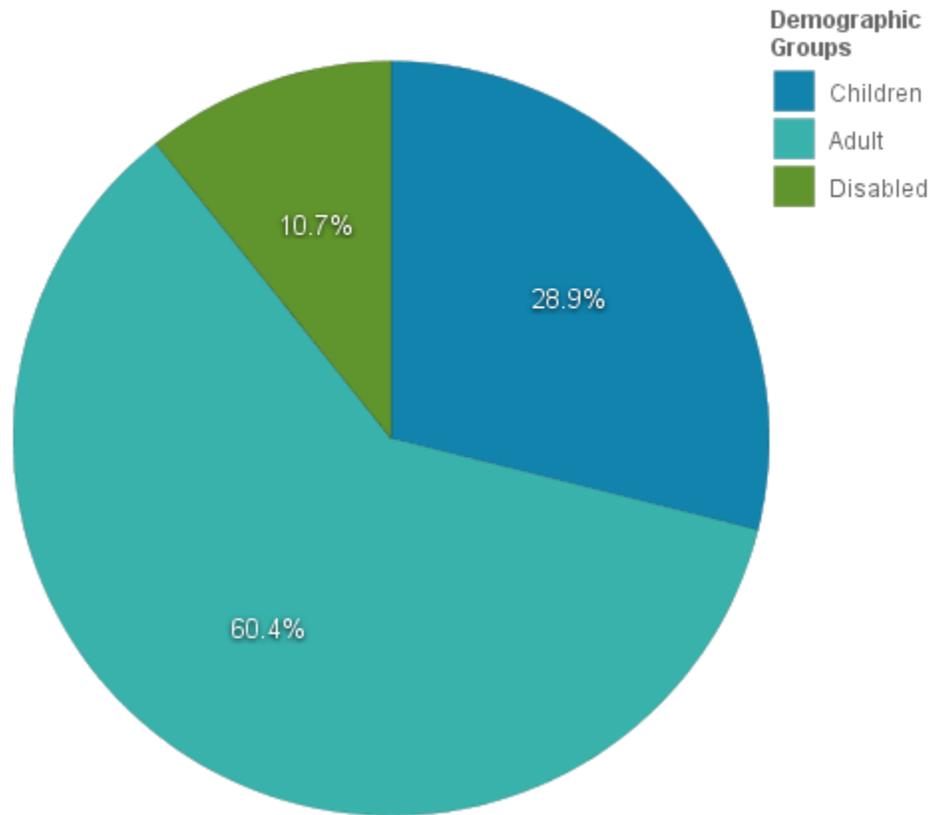


Figure 51 – Physician Specialist Services percentage of utilizers, by demographic groups

Analysis of Demographic Groups

One third of total Medicaid members accessed specialty services during FY 14-15 (433,598 utilizers). Adults made up a majority of specialty care utilizers (60%), which aligned with the general Health First Colorado population. In addition, because children tend to be healthier, it is not surprising that a higher number of adults sought specialty care services. The small percentage of utilizers with disabilities aligns with expectations because members with disabilities make up the smallest Health First Colorado demographic. These statistics are consistent with expectations and, as such, does not indicate an access issue, but can only be interpreted in context with other statistics.

Figure 52 is a FY 2014-15 snapshot of gender groups by utilizer count. This shows the gender distribution of service utilizers. *Fulfills requirement 42 CFR 447.203(b)(1)(iv)*

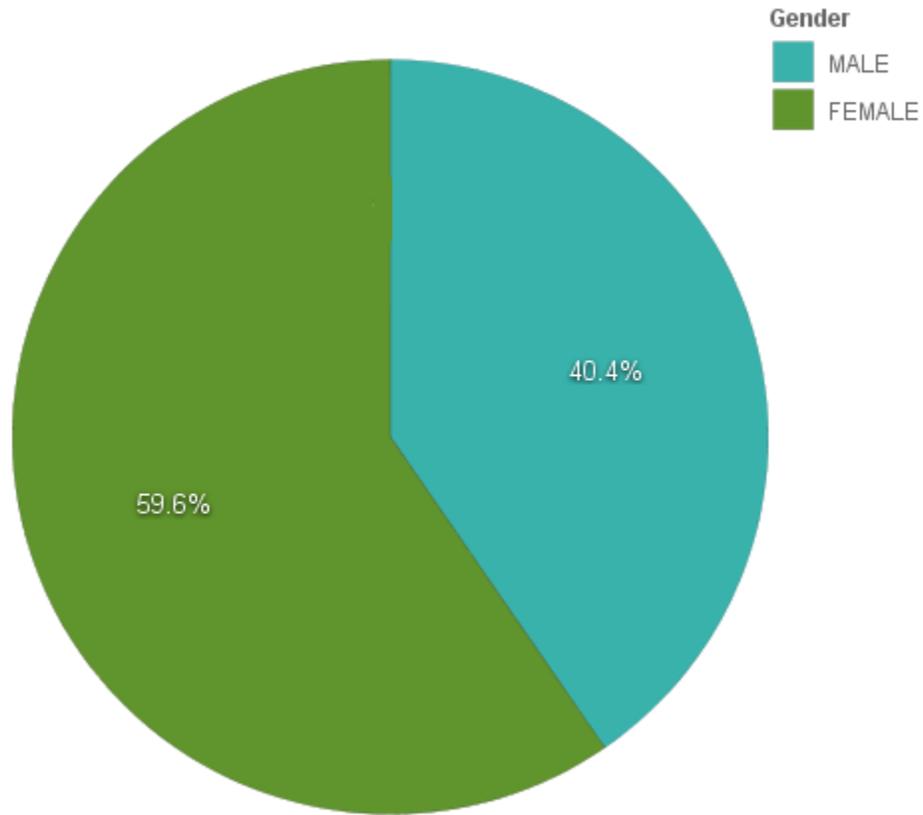


Figure 52 - Physician Specialist Services percentage of utilizers, by gender

Analysis of Gender Groups

The majority of specialty care utilizers, in FY 2014-15, were female (60%). While the gender split of the total Health First Colorado population mirrored that of the general Colorado population, the large proportion of female members who utilized services is not surprising considering women tend to utilize the health care system more often than men. This statistic is consistent with expectations and, as such, does not indicate an access issue, but can only be interpreted in context with other statistics.

Figure 53 is a FY 2014-15 snapshot of age groups by utilizer count. This depicts the age distribution of service utilizers. *Fulfills requirement 42 CFR 447.203(b)(1)(iv)*

Physician Specialty Care Utilizer Age Groups

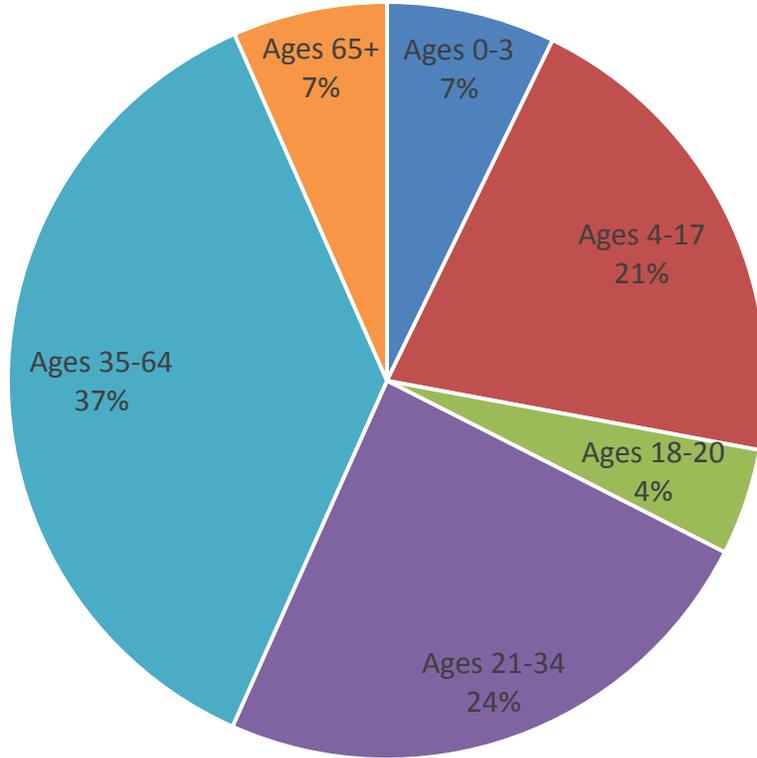


Figure 53 - Physician Specialist Services percentage utilizers, by age

Analysis of Age Groups

The age distribution of specialty care utilizers was similar to the demographic breakdown, in that the majority of utilizers were over the age of 18 (72%). This statistic is consistent with expectations and, as such, does not indicate an access issue, but can only be interpreted in context with other statistics.

Table 6 is a FY 2014-15 snapshot of top 10 diagnoses by utilizer count, further broken out by demographic group. It includes what percentage of total service utilizers each demographic group constituted. This characterizes the needs of the beneficiary population. *Fulfills requirement 42 CFR 447.203(b)(1)(iv)*

<u>Top 10 Root Diagnosis Codes</u>		
Rank: 1 Principal Diagnosis 786		
Code Description SYMPTOMS INVOLVING RESPIRATORY SYSTEM & OTHER CHEST SYMPTOMS		
Total Members: 67,717		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	44,538	65.8%
Children	13,216	19.5%
Individuals with Disabilities	9,963	14.7%
Rank: 2 Principal Diagnosis 789		
Code Description OTHER SYMPTOMS INVOLVING ABDOMEN & PELVIS		
Total Members: 45,089		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	31,275	69.4%
Children	8,304	18.4%
Individuals with Disabilities	5,510	12.2%
Rank: 3 Principal Diagnosis 719		
Code Description OTHER & UNSPECIFIED DISORDERS OF JOINT		
Total Members: 38,085		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	24,499	64.3%
Children	8,475	22.3%
Individuals with Disabilities	5,111	13.4%
Rank: 4 Principal Diagnosis 959		
Code Description INJURY, OTHER & UNSPECIFIED		
Total Members: 33,042		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	18,691	56.6%
Children	10,551	31.9%
Individuals with Disabilities	3,800	11.5%
Rank: 5 Principal Diagnosis 780		
Code Description GENERAL SYMPTOMS		
Total Members: 30,532		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	17,169	56.2%
Children	7,972	26.1%

Individuals with Disabilities	5,391	17.7%
Rank: 6 Principal Diagnosis 729		
Code Description OTHER DISORDERS OF SOFT TISSUES		
Total Members: 28,186		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	18,357	65.1%
Children	5,367	19.0%
Individuals with Disabilities	4,462	15.8%
Rank: 7 Principal Diagnosis V72		
Code Description SPECIAL INVESTIGATIONS & EXAMINATIONS		
Total Members: 19,427		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	15,956	82.1%
Children	1,816	9.3%
Individuals with Disabilities	1,655	8.5%
Rank: 8 Principal Diagnosis 724		
Code Description OTHER & UNSPECIFIED DISORDERS OF BACK		
Total Members: 18,989		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	14,440	76.0%
Children	1,544	8.1%
Individuals with Disabilities	3,005	15.8%
Rank: 9 Principal Diagnosis 367		
Code Description DISORDERS OF REFRACTION & ACCOMMODATION		
Total Members: 18,325		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	4,075	22.2%
Children	13,038	71.1%
Individuals with Disabilities	1,212	6.6%
Rank: 10 Principal Diagnosis 784		
Code Description SYMPTOMS INVOLVING HEAD & NECK		
Total Members: 17,448		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	11,972	68.6%
Children	2,976	17.1%
Individuals with Disabilities	2,500	14.3%

Table 6 - Physician Specialist Services top 10 root diagnoses by utilizer count

Analysis of Top 10 Diagnoses

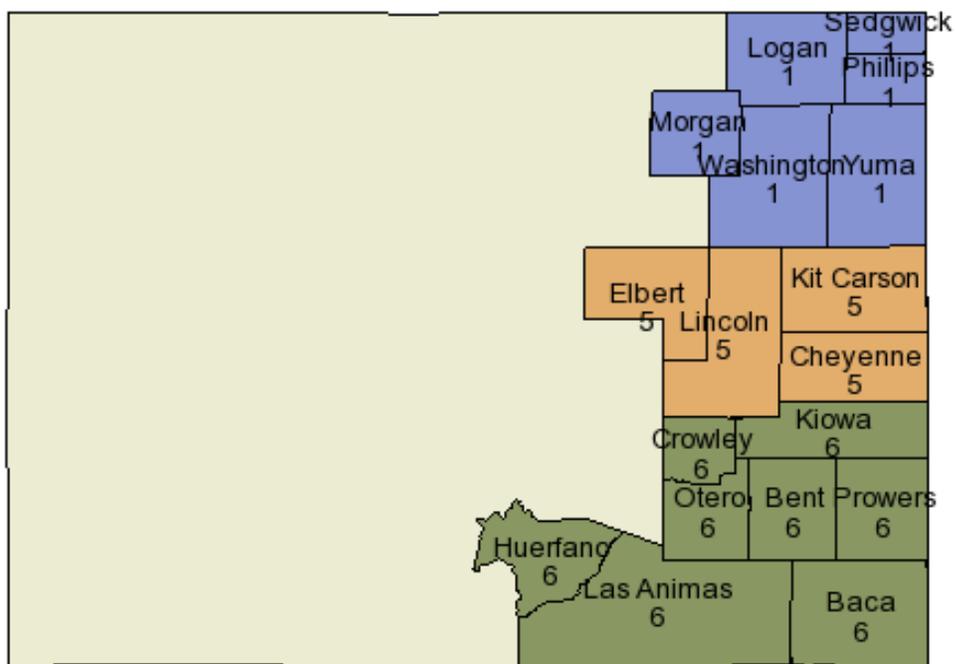
The most common diagnoses for specialty care utilizers overall included disorders of the respiratory and musculoskeletal systems, joints, and symptoms related to pain, swelling, and lack of consciousness. For children, the most common diagnosis was disorders of refraction (ex. Vision issues) and symptoms involving the respiratory system (include coughing, shortness of breath, and chest pain). For individuals with disabilities, the most common diagnoses for specialty services were respiratory symptoms, symptoms involving abdomen and pelvis (abdominal pain, swelling, and tenderness), and general symptoms such as fainting, convulsions, and fever.

Physician Specialist Services Utilization Analysis by Geographic Region

To best review access to health care services for Health First Colorado members, through the lense of administrative claims utilization data, the Department plotted three sets of data points, stratified by each HSR. These were the total volume utilizer count, the active billing provider count, and the service penetration rate.²⁹ What follows is a graphical examination of 18 month trends for each of seven groupings of HSRs. Only the utilization of members for whom Health First Colorado was the payer are shown

HSRs 01, 05, and 06

Predominately rural, these HSRs account for approximately 3.1% of the State's overall population.



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Figure 54 - Diagram of HSRs 01, 05, 06

²⁹ If Medicaid members utilized other services that were paid for by their private insurance or Medicare, that utilization is not captured here.

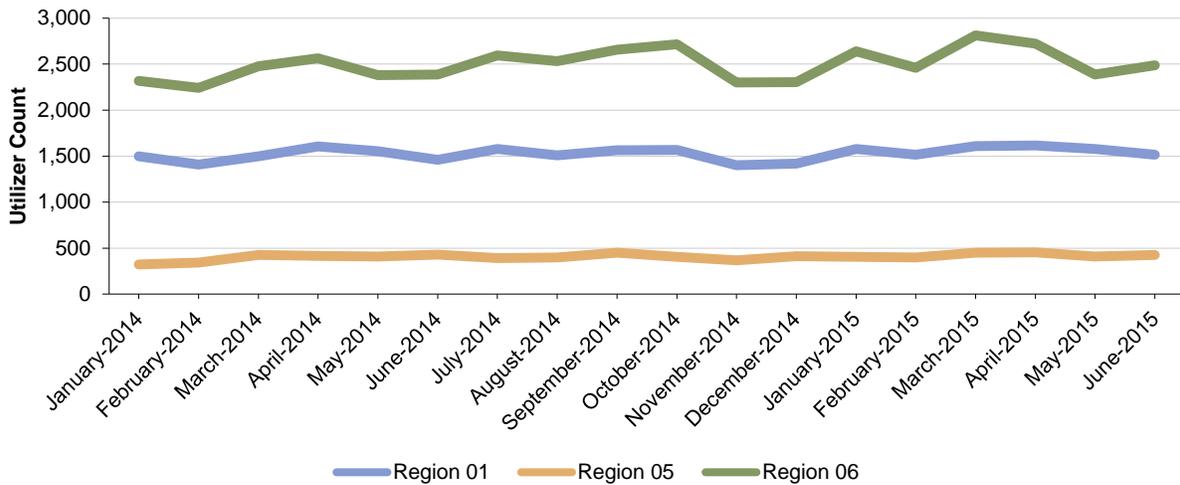


Figure 55 - Physician Specialist Services utilizer count, HSRs 01, 05, 06

The utilizer count for Region 06 was larger than that of Regions 01 and 05. According to CHAS data from 2015, insured persons in Region 06 were approximately 7% more numerous than in Region 01, and 34% more numerous than in Region 05, which would account for a larger utilizer count in Region 06.

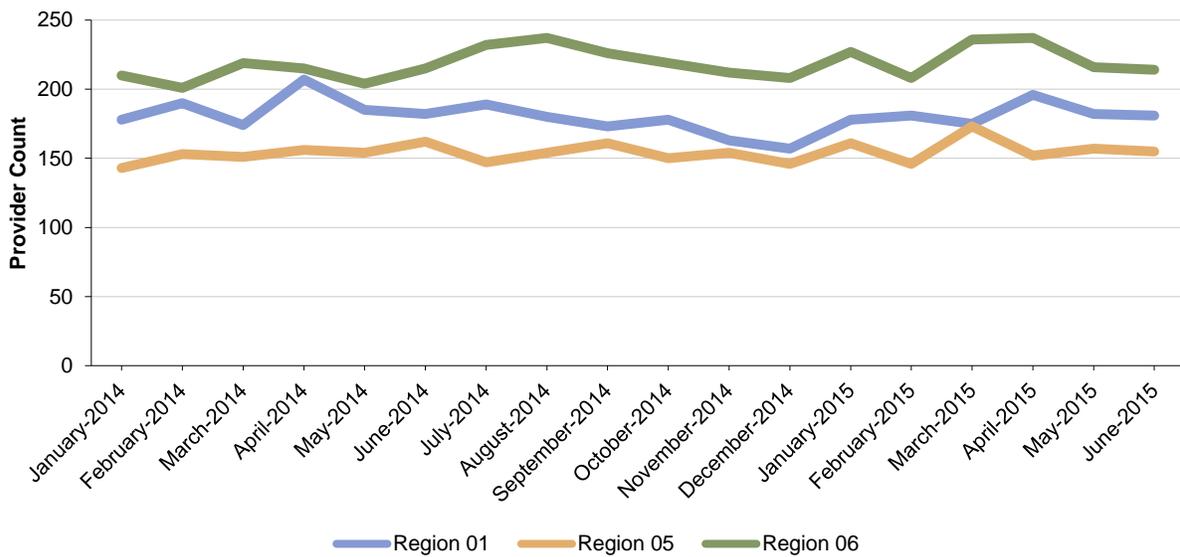


Figure 56 - Physician Specialist Services provider count, HSRs 01, 05, 06

Again, while the number of providers in Region 06 was larger than that of Regions 01 and 05, the difference is not concerning and would make sense given the population breakdown of insured persons.

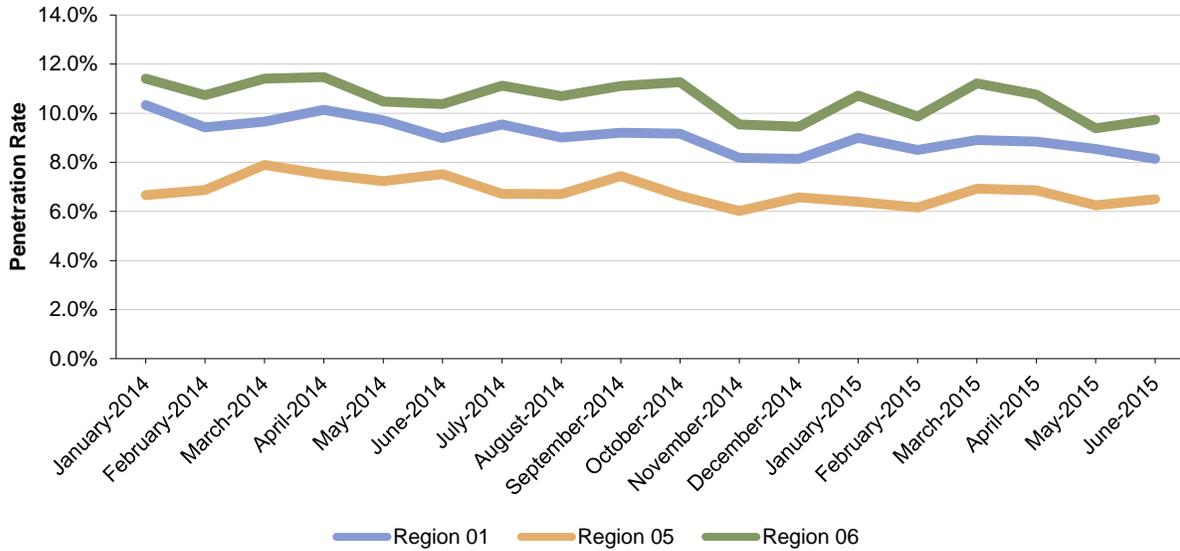


Figure 57 - Physician Specialist Services penetration rate, HSRs 01, 05, 06

The penetration rates for these regions appear relatively stable year-over-year with Regions 06 and 01 reporting higher levels, however this aligns with the aforementioned data regarding member and provider count.

Analysis of HSRs 01, 05, and 06

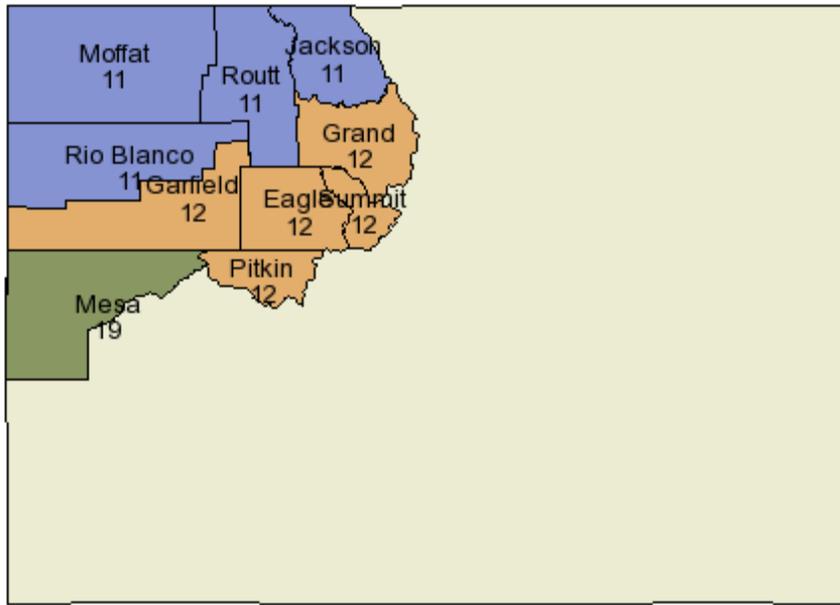
The utilizer and provider counts in all three regions fluctuated monthly, with increases in March and April of both years. Despite the monthly variance, numbers remained stable year-over-year. The penetration rates in all three regions fluctuated similarly with small overall decreases during the measurement timeframe.

Based on member and provider count, the penetration rate, and the USOC statistics, the data does not indicate an access issue for these regions.

HSRs 11, 12, and 19

Health Statistic Regions 11, 12, and 19 are comprised of residents from the north-western part of the State. These three regions reported having approximately 297,000 insured persons in 2013, and grew to approximately 321,000 insured persons by 2015.

Predominately rural and mountainous, with one major urban center, these HSRs account for approximately 5.8% of the State's overall population.



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Figure 58 – Diagram of HSRs 11, 12, 19

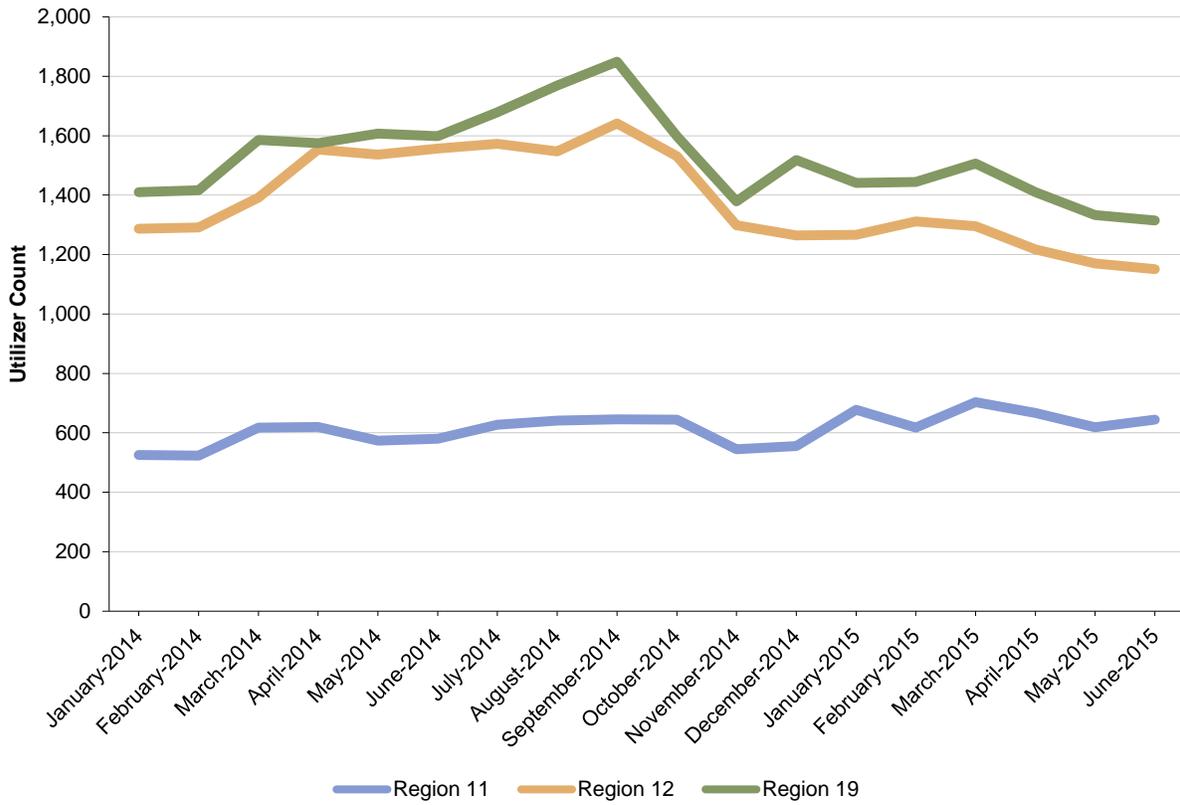


Figure 59 - Physician Specialist Services utilizer count, HSRs 11, 12, 19

The utilizer counts in Regions 12 and 19 were higher than that of Region 11. This aligns with the overall payer populations of these HSRs. According to CHAS data, Regions 12 and 19 are approximately three times as large as Region 11, which would account for the larger count. The number of Medicaid members who utilized Physician Specialty Services in Region 19 was higher than those who utilized Primary Care Services in the region. While this does not necessary indicate an access issue, it is something that warrants further examination.

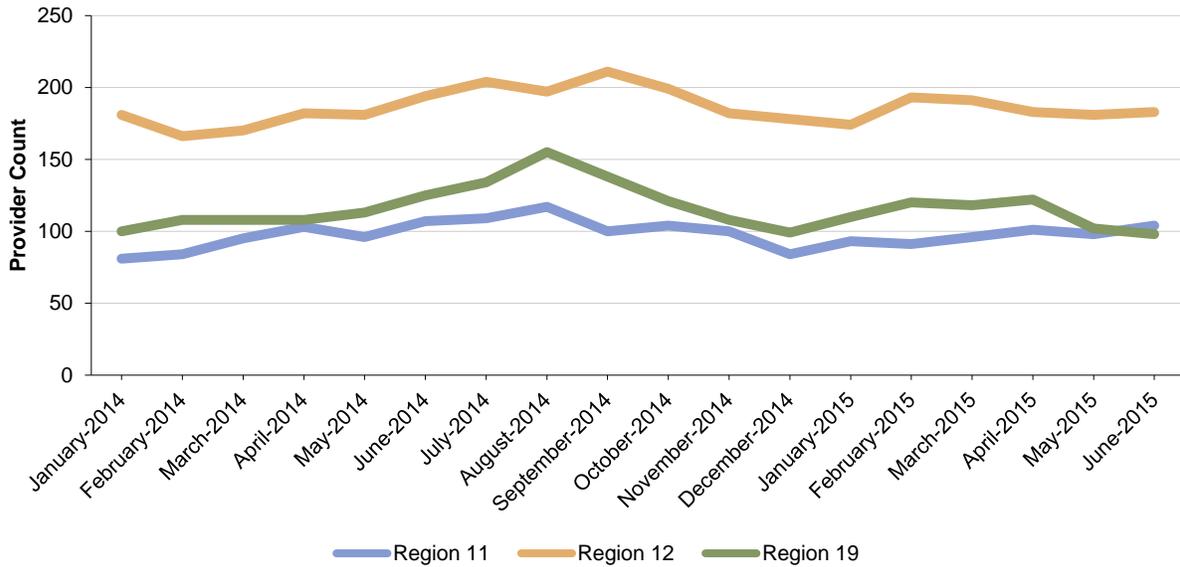


Figure 60 - Physician Specialist Services provider count, HSRs 11, 12, 19

Looking at provider count, it would seem logical for the highest number of providers to exist in Regions 12 and 19. While this was indeed the case, it would appear that the number of providers for Region 19 should be larger, to account for the larger population of Medicaid members (as seen in Figure 59 above).

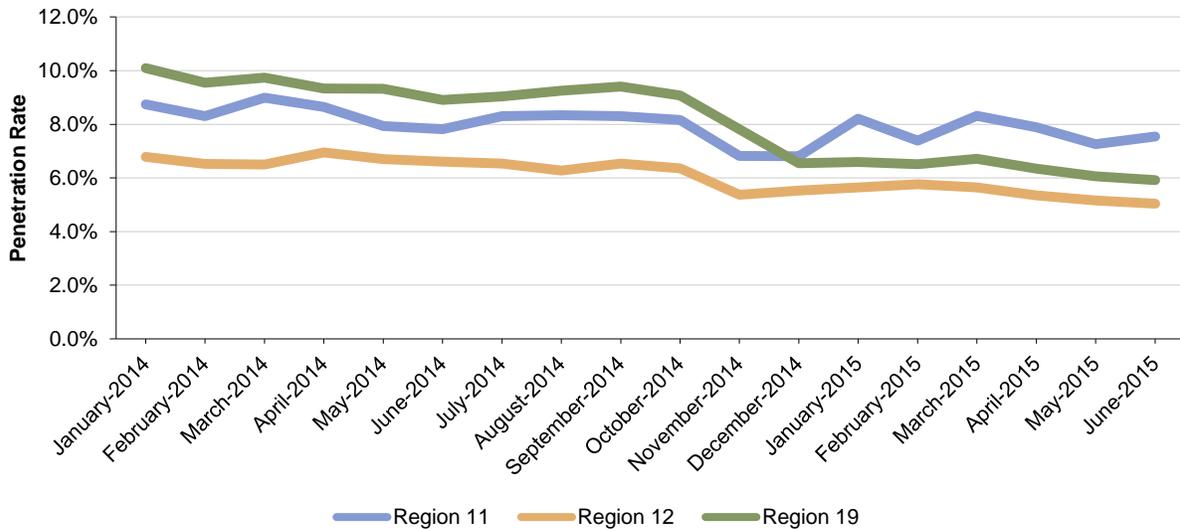


Figure 61 - Physician Specialist Services penetration rate, HSRs 11, 12, 19

Penetration rate trends for Regions 11 and 12 appear stable. Region 19 saw a decrease, from 10% in January 2014 to 6% by December 2014. Although the trend is now stable, this dip reflects the shift of utilization to the Rocky Mountain Health Plan (RMHP) managed care plan in that area. The utilization of Health First Colorado benefits, provided by RMHP, is not included in this report because it is through a managed care delivery model.³⁰

Analysis for HSRs 11, 12, and 19

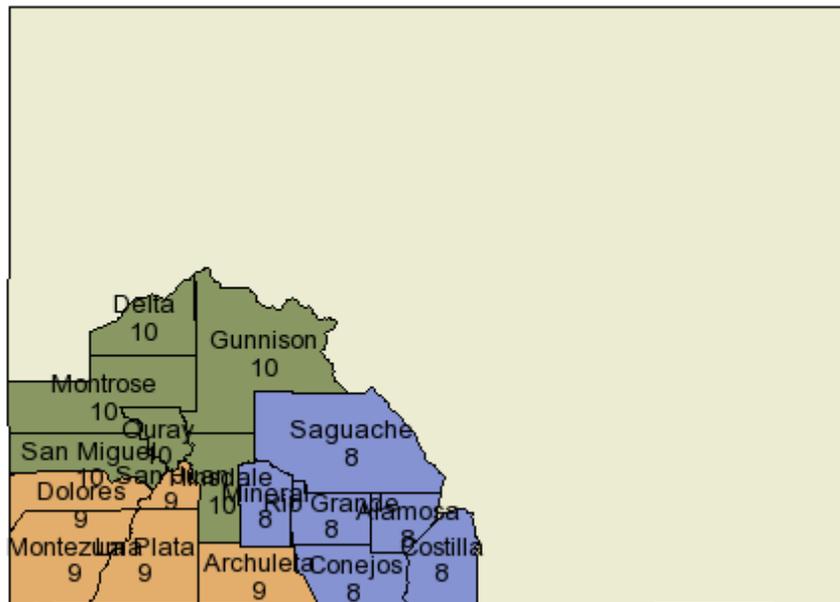
Region 11 utilizer and provider counts showed minimal monthly variance and were stable. Utilizer and provider counts in Regions 12 and 19 mirror one another, with increases in March 2014 and peaking in September, before decreasing in November of that year.

The graphs demonstrate similar trends in March 2015, indicating normal variance for both measures. The sharp drop in the HSR 19 penetration rate also reflects the shift of utilization to the newly created RMHP delivery system. This shift in enrollment is also true for Montrose and Rio Blanco counties, however, this change is likely not as evident as these counties are within a larger multi-county region.

HSRs 08, 09, and 10

Health Statistic Regions 08, 09, and 10 are comprised of residents from the south-western part of the State. These three regions reported approximately 196,000 insured persons in 2013, and grew to approximately 199,000 insured persons by 2015.

Predominately rural and mountainous, these HSRs account for approximately 3.6% of the State's overall population.



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Figure 62 - Diagram of HSRs 08, 09, 10

³⁰ Refer to pages 48-49 for a detailed explanation of the move to the Rocky Mountain Health Plan.

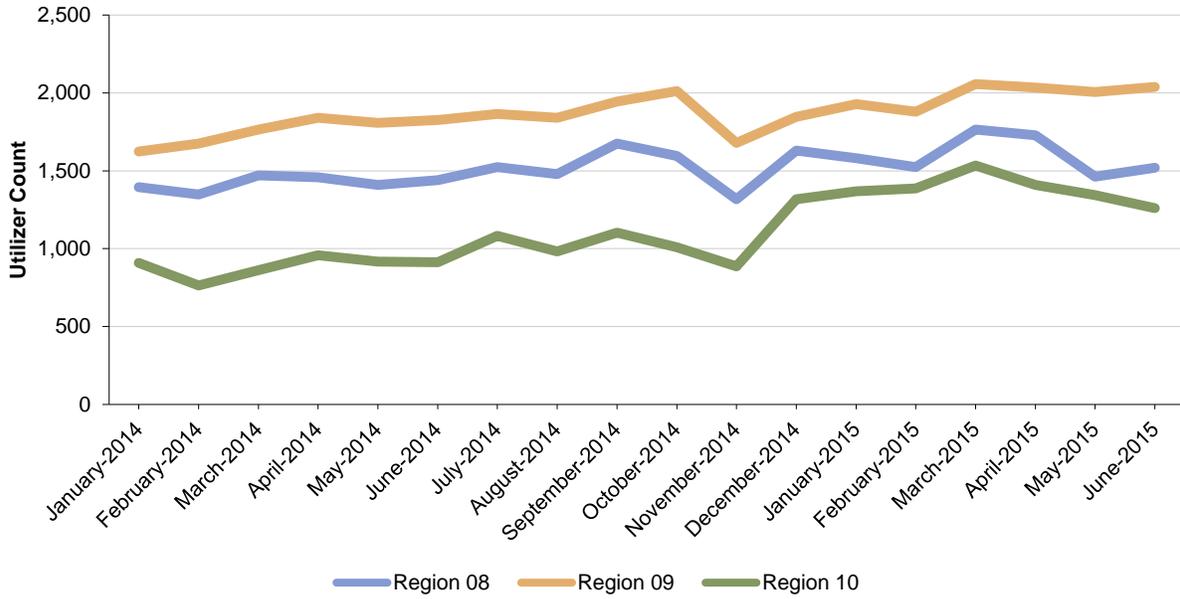


Figure 63 – Physician Specialist Services utilizer count, HSRs 08, 09, 10

Despite different utilizer numbers, the three regions’ specialty service utilizer count showed similar fluctuations, with steady increases between January and October and then sharp drops in November 2014.

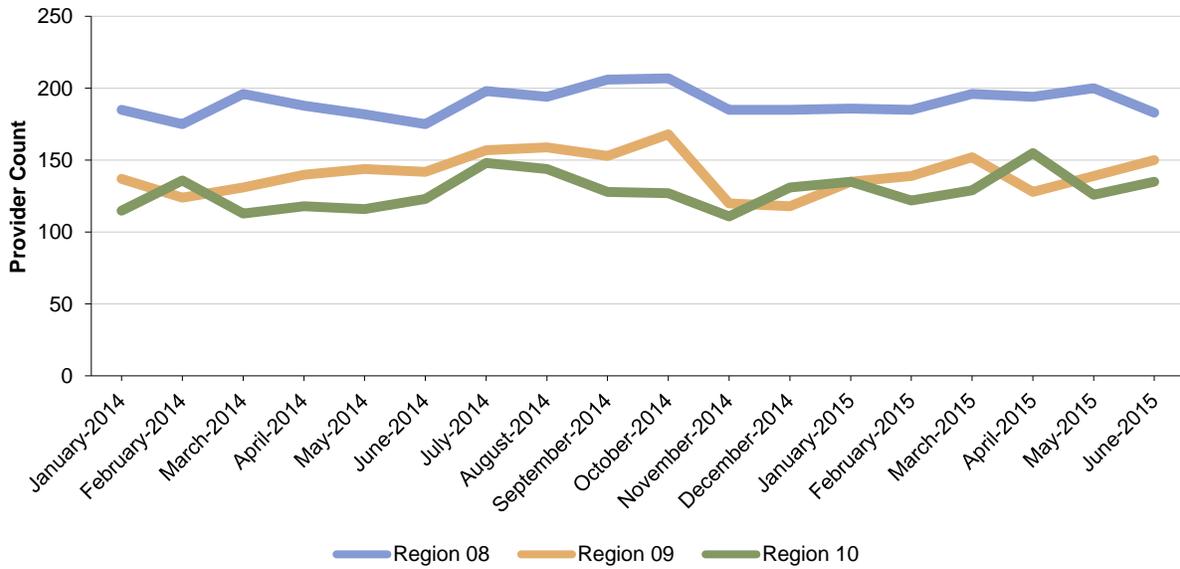


Figure 64 - Physician Specialist Services provider count, HSRs 08, 09, 10

The provider counts were relatively stable during this time period.

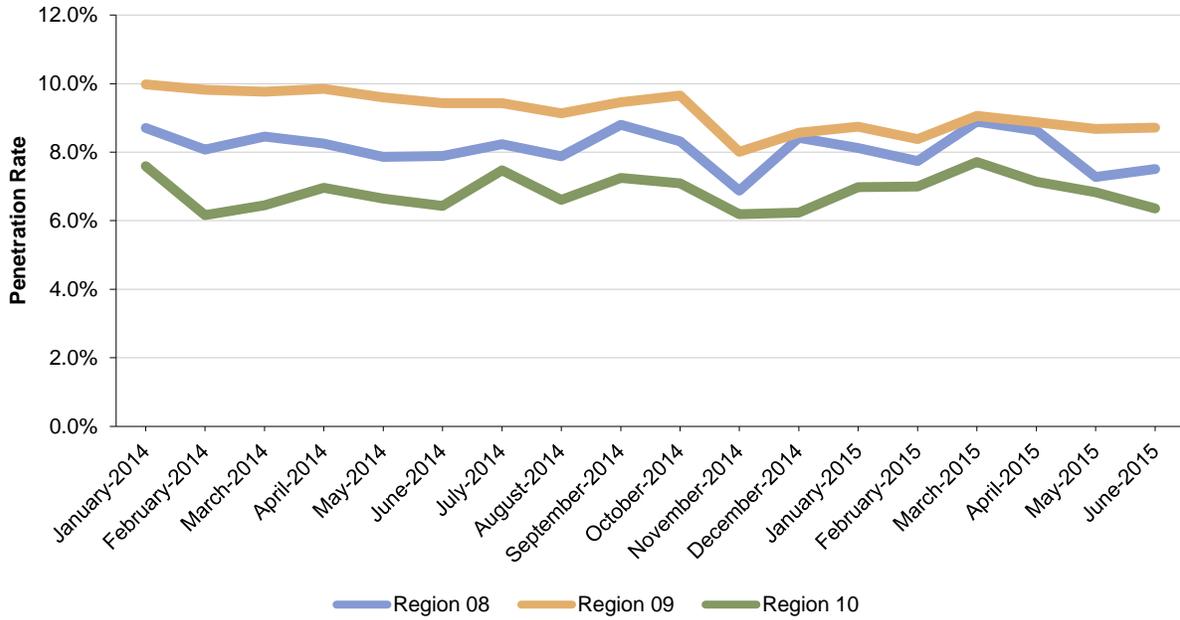


Figure 65 - Physician Specialist Services penetration rate, HSRs 08, 09, 10

Penetration rates for Regions 08, 09, and 10 all decreased moderately year-over-year, which is likely the result of Medicaid expansion, which took effect in January 2014. During this time, many more utilizers of a different demographic group were enrolled in Medicaid. This would increase the denominator of the penetration rate equation (utilizer count divided by eligible utilizers), which would decrease the penetration rate overall if the newly enrolled did not access specialty services at historical rates.

Analysis for HSRs 08, 09, and 10

HSRs 08, 09, and 10 show no indicators of an access issue.

HSRs 04, 07, and 13

Health Statistic Regions 04, 07, and 13 are comprised of residents in the central to southern part of the State. These three regions reported approximately 750,000 insured persons in 2013, and grew to approximately 800,000 insured persons by 2015.

A mix of urban and rural with some mountainous regions, these HSRs account for approximately 14.6% of the State's overall population.



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Figure 66 - Diagram of HSRs 04, 07, 13

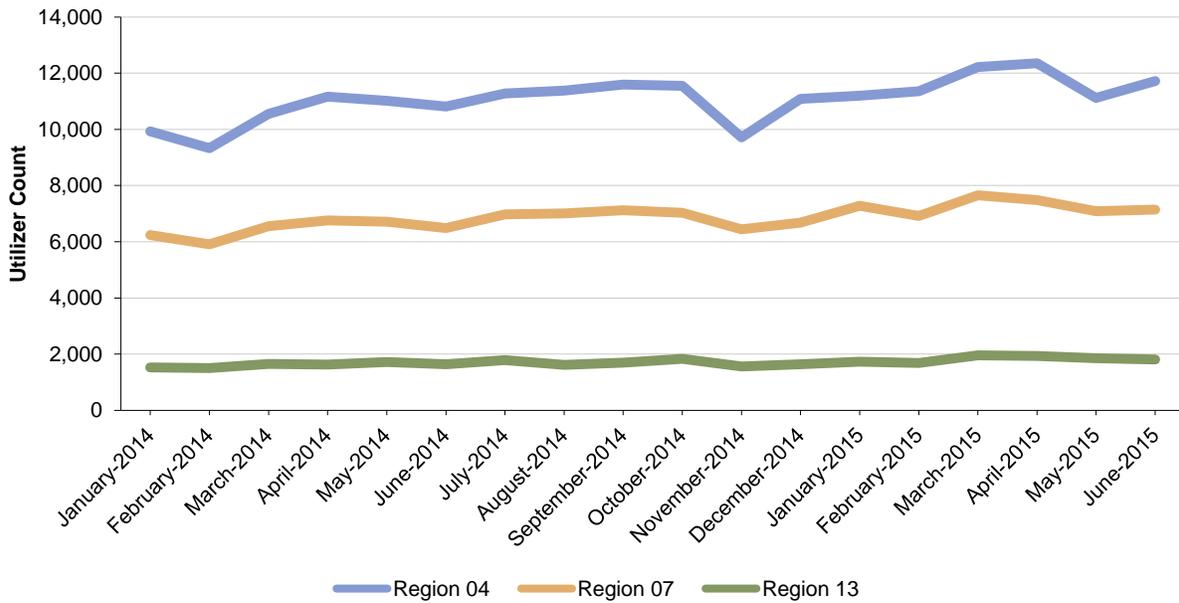


Figure 67 - Physician Specialist Services utilizer count, HSRs 04, 07, 13

The utilizer count remained relatively stable from 2014 to 2015, with minimal dips in October-November 2014 and small increases in May-June 2015. While there were a larger number of utilizers in Region 04, this appears to align with CHAS data, which estimates that the population of insured persons in Region 04 is approximately four times larger than Region 07, and approximately nine times larger than Region 13.

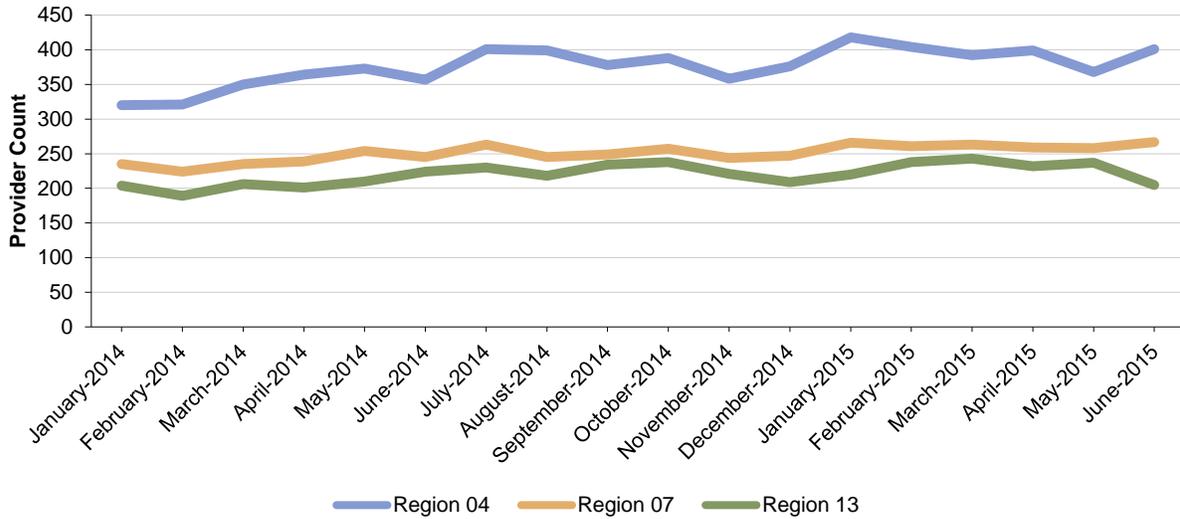


Figure 68 - Physician Specialist Services provider count, HSRs 04, 07, 13

Trends observed in the utilizer count for these HSRs can also be seen in the number of providers. Larger provider counts appear in Region 04 which makes sense given the larger population of Medicaid members in this region. In general, provider counts appear stable year-over-year.

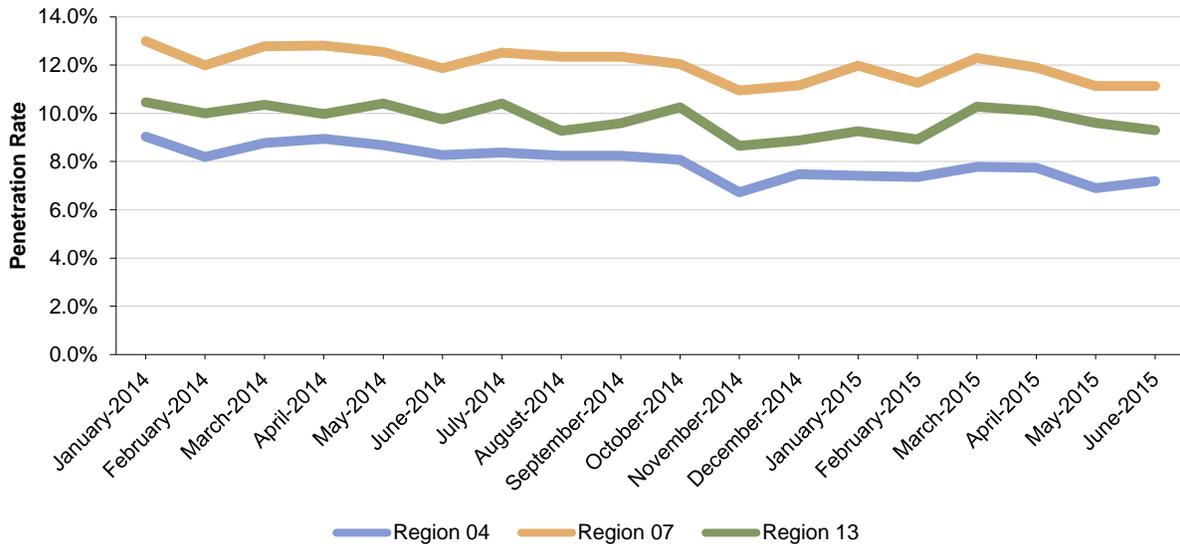


Figure 69 - Physician Specialist Services penetration rate, HSRs 04, 07, 13

The penetration rate for these regions does not appear to align with the utilizer and provider counts; Region 04 utilized specialty care services far less than the smaller regions that make up HSRs 07 and 13. Such variations in trends between HSRs will be investigated during regular review and monitoring to more closely understand what causes them.

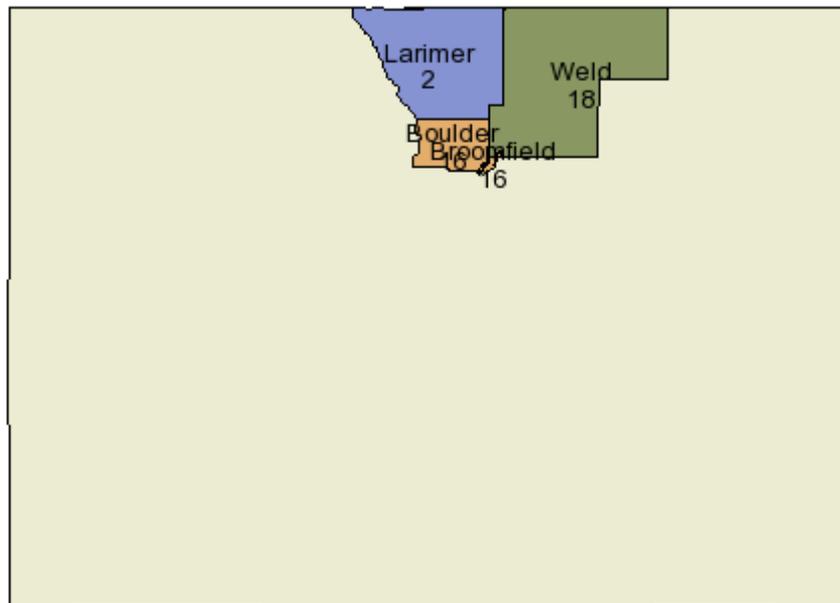
Analysis for HSRs 04, 07, and 13

HSRs 04, 07, and 13 are comprised of counties located in central Colorado, including the cities of Colorado Springs and Pueblo. Utilizer and provider counts increased between January 2014 and June 2015 in all three regions. Penetration in Region 04 experienced minimal fluctuation with a steady decrease. However, with increasing utilizer and provider counts across the measurement timeframe, data does not indicate an access issue in Region 04. Region 07's penetration rate was the highest in January of each year, before slight decreases, but this does not yet indicate an access issue.

HSRS 02, 16, and 18

Health Statistic Regions 02, 16, and 18 are comprised of residents in the central and northern part of the State. These three regions reported approximately 770,000 insured persons in 2013, and grew to approximately 825,000 insured persons by 2015.

Predominately rural and somewhat mountainous, with numerous urban centers, these HSRs account for approximately 15.1% of the State's overall population.



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Figure 70 - Diagram of HSRs 02, 16, 18

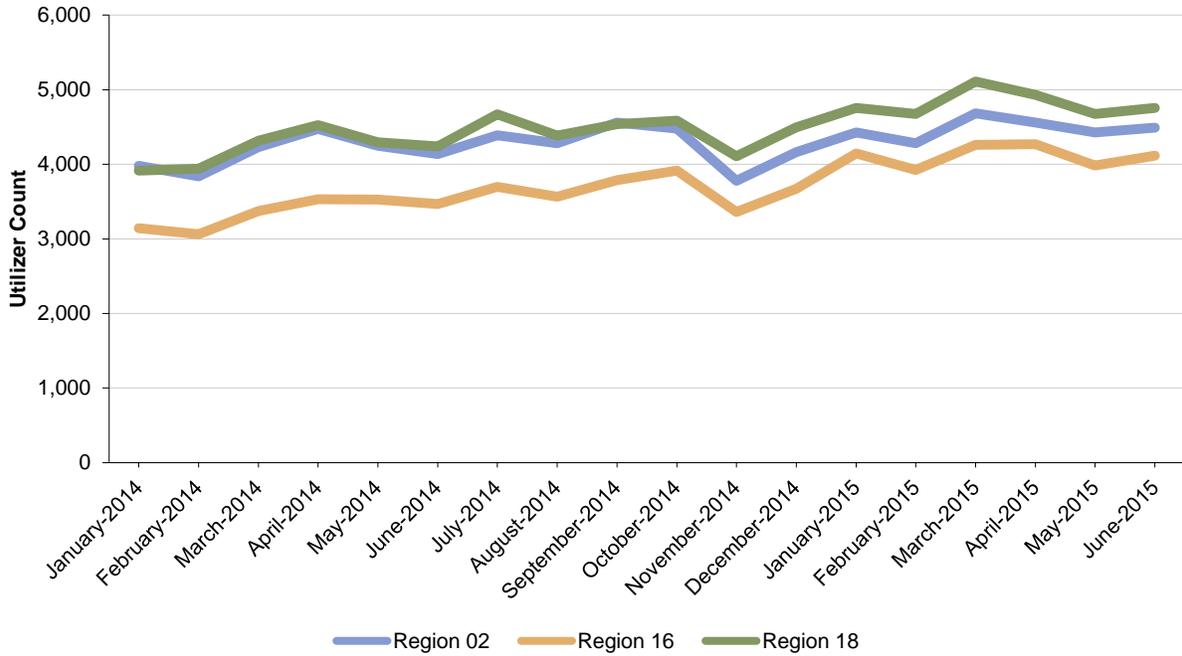


Figure 71 - Physician Specialist Services utilizer count, HSRs 02, 16, 18

When analyzing Medicaid member utilization of services in these regions, it appears that **utilizer counts** increased substantially in all three regions between January 2014 and June 2015, despite small dips in November 2014.

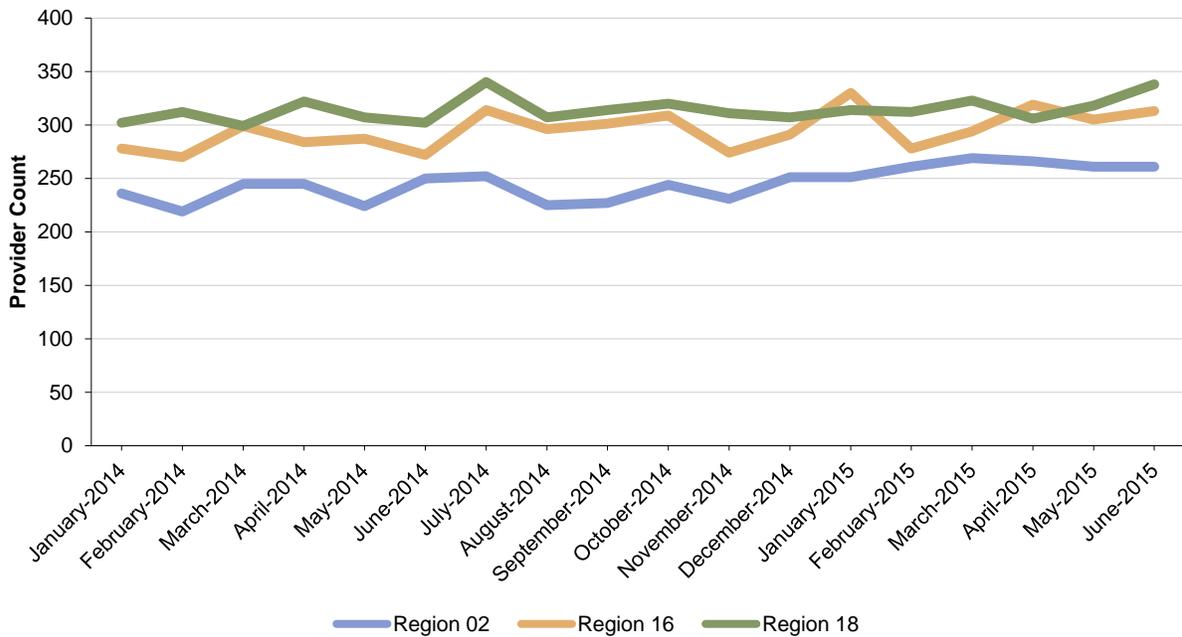


Figure 72 - Physician Specialist Services provider count, HSRs 02, 16, 18

Provider counts experienced monthly fluctuation with an overall increase as well.

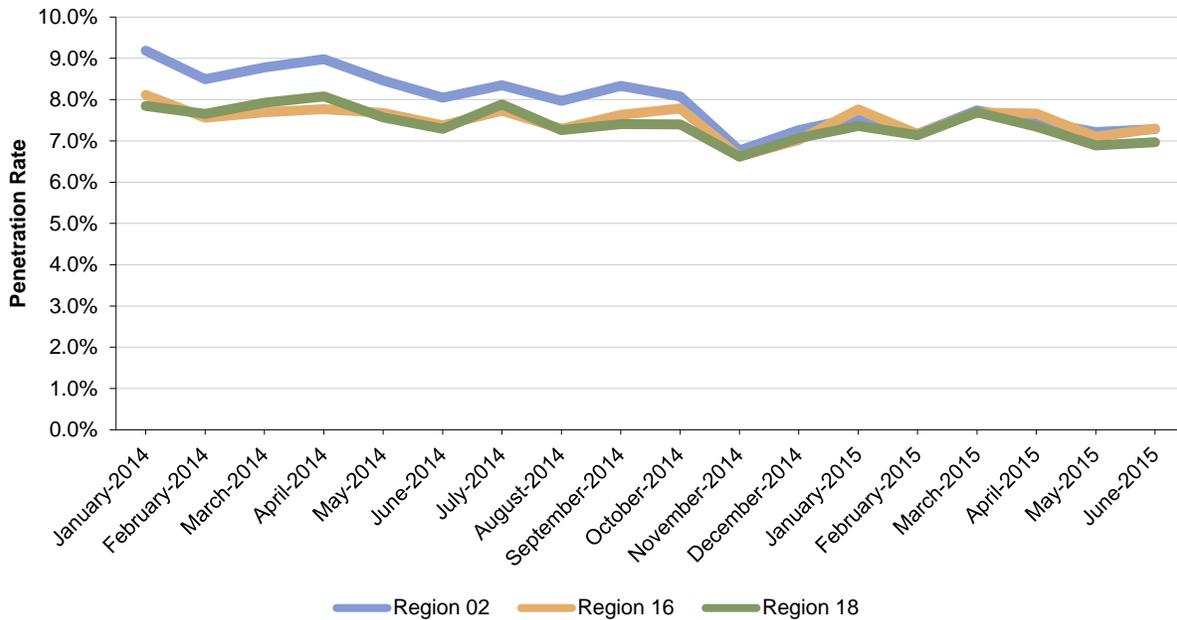


Figure 73 - Physician Specialist Services penetration rate, HSRs 02, 16, 18

Penetration rates in these three regions followed the same variance during the measurement time frame, ending with a slight decrease.

Analysis for HSRs 02, 16, and 18

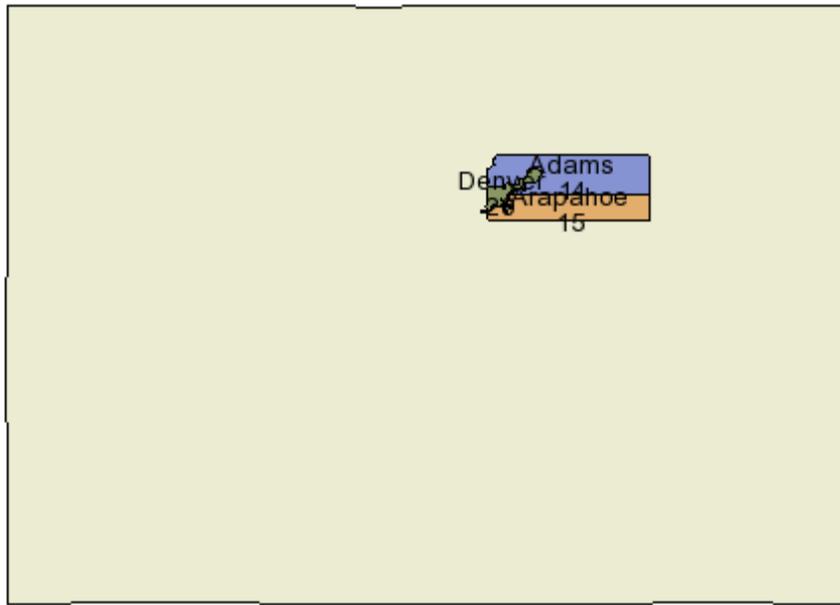
HSRs 2, 16, and 18 include the cities of Fort Collins, Boulder, and Greeley.

During the public comment phase of this Plan, the Department received feedback that there may be an access issue for Physician Specialist Services in HSR 16. This will be investigated further and reported on in the next version of the Plan.

HSRs 14, 15, and 20

Health Statistic Regions 14, 15, and 20 are comprised of residents in the central part of the State. These three regions reported approximately 1,333,000 insured persons in 2013, and grew to approximately 1,377,000 insured persons by 2015.

Predominately urban, geographically, these HSRs account for approximately 25.2% of the State's overall population.



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Figure 74 - Diagram of HSRs 14, 15, 20

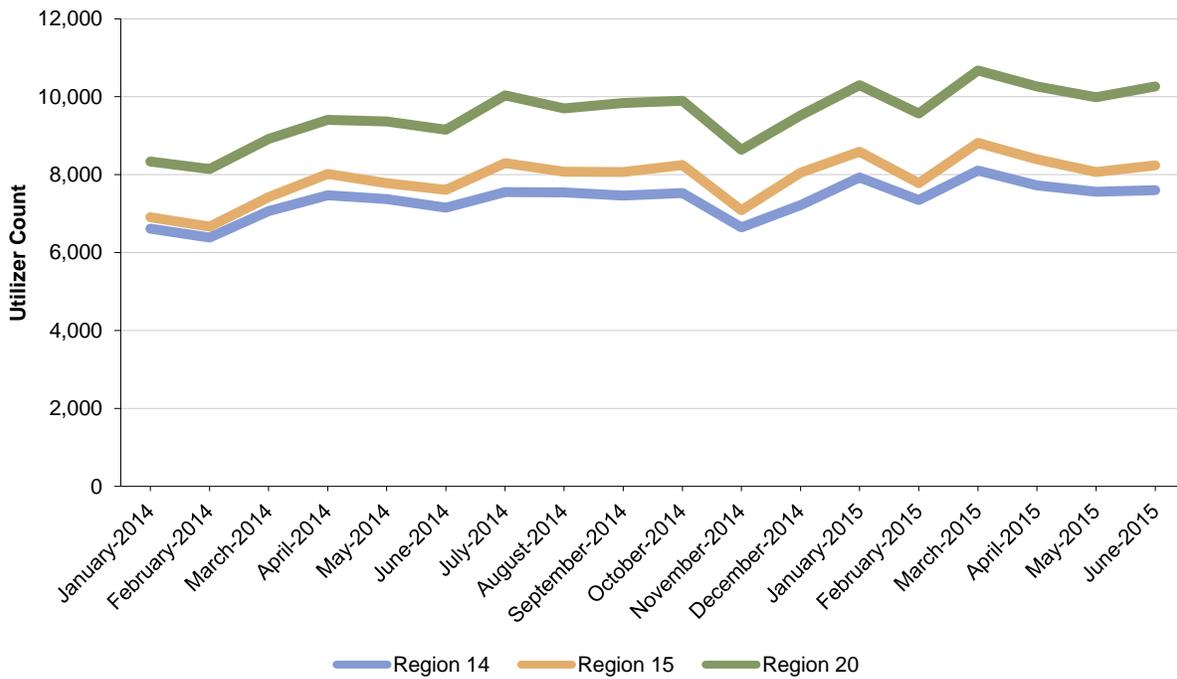


Figure 75 - Physician Specialist Services utilizer count, HSRs 14, 15, 20

The utilizer count in these regions appears relatively stable, with moderate increases beginning in November 2014.

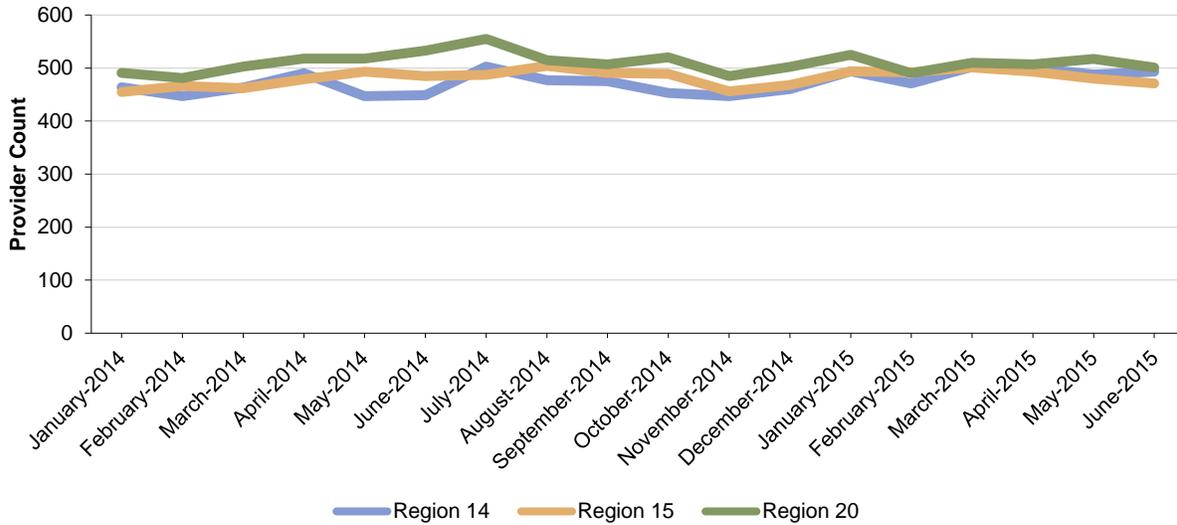


Figure 76 - Physician Specialist Services provider count, HSRs 14, 15, 20

Provider count also remained relatively stable year-over-year.

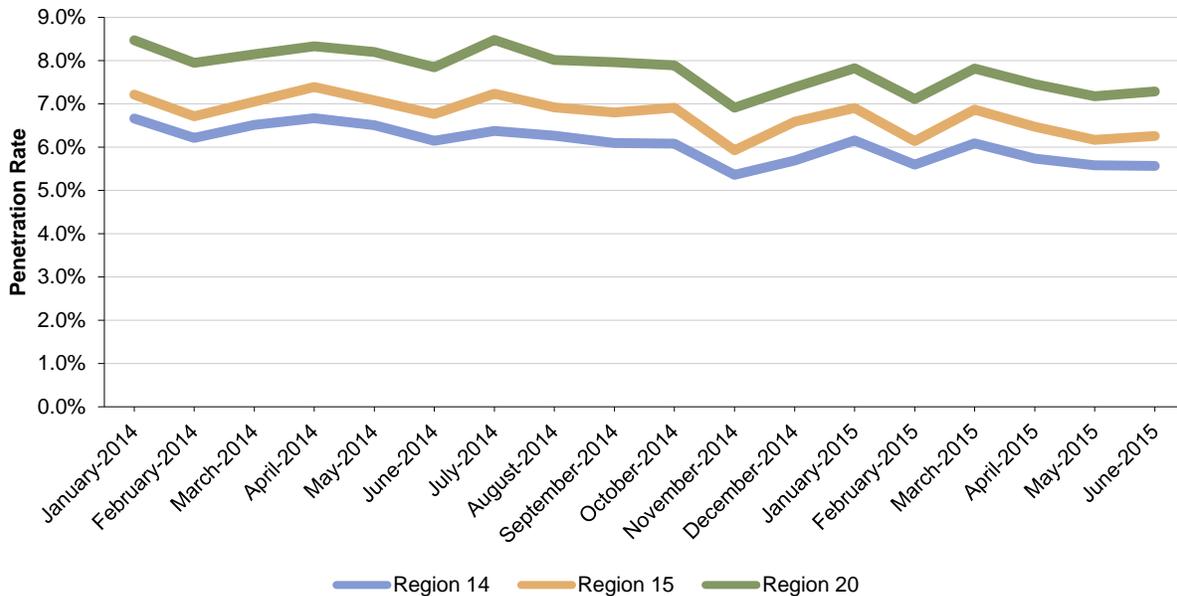


Figure 77 - Physician Specialist Services penetration rate, HSRs 14, 15, 20

The penetration rates appear relatively stable, with mild decreases in utilization beginning in November 2014.

Analysis for HSRs 14, 15, and 20

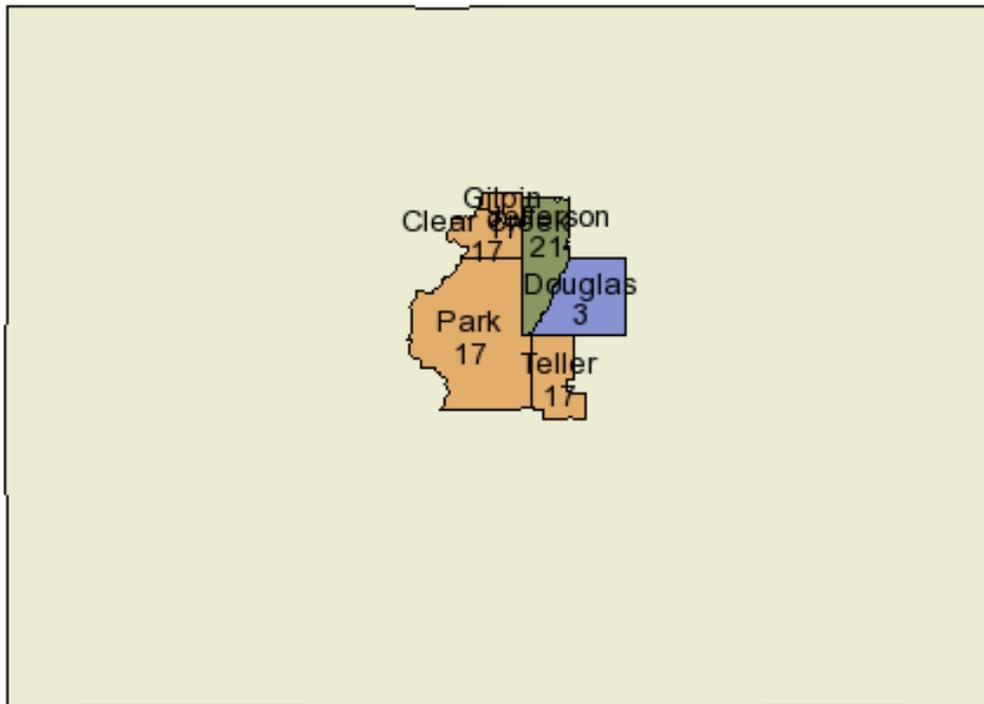
HSRs 14, 15, and 20 include the city and county of Denver and the surrounding east metro area. All three regions experienced similar fluctuation in utilizer counts, provider counts, and penetration rates. The increase in utilizer counts and decrease in penetration rates, while provider counts remained relatively stable, is likely the result of Medicaid expansion, which took effect in January 2014.

The Department will monitor the trends in the State’s largest metro area to ensure access, but the data does not indicate an access issue at this time.

HSRs 03, 17, and 21

Health Statistic Regions 03, 17, and 21 are comprised of residents in the central part of the State. These three regions reported approximately 79,000 insured persons in 2013, and grew to approximately 876,000 insured persons by 2015.

A mix of urban and rural geography, these HSRs account for approximately 16% of the State's overall population.



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Figure 78 – Diagram of HSRs 03, 17, 21

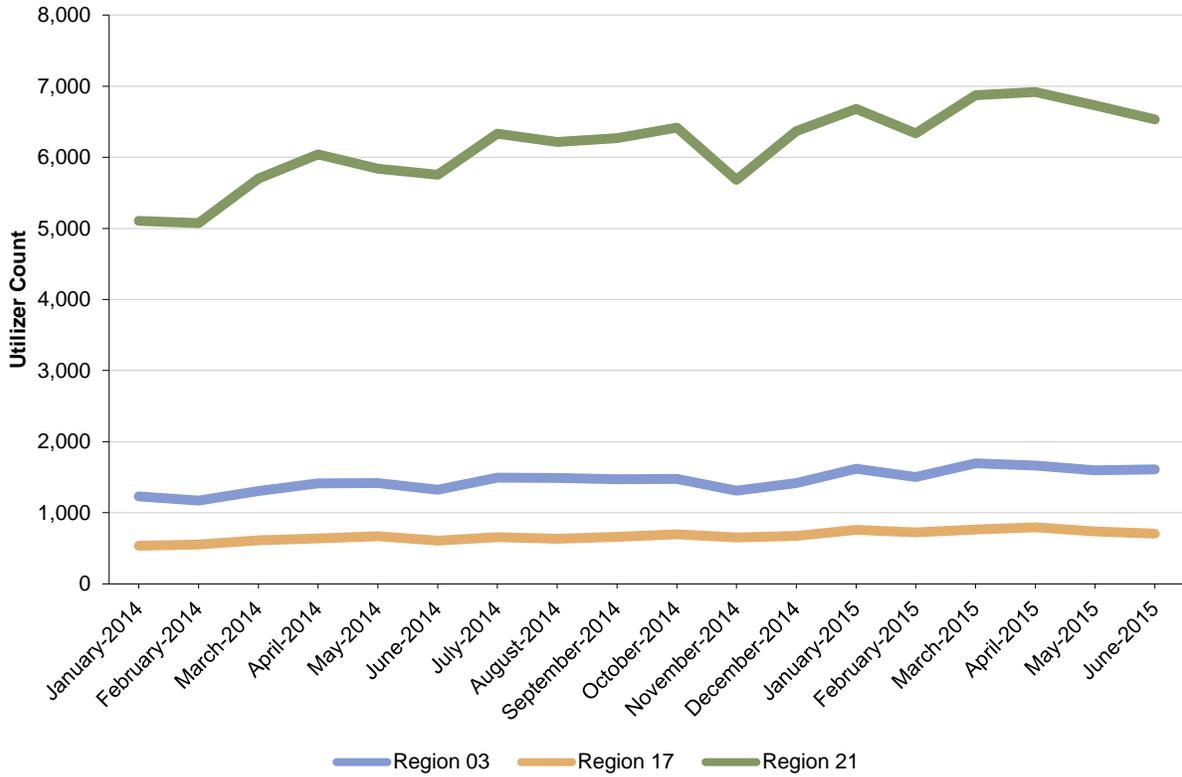


Figure 79 - Physician Specialist Services utilizer count, HSRs 03, 17, 21

The Utilizer count in Region 21 was larger than that of Regions 03 and 17. This appears to align with CHAS data, which estimates Region 21 to have approximately two times as many insured persons than Region 03, and approximately nine times that of Region 17.

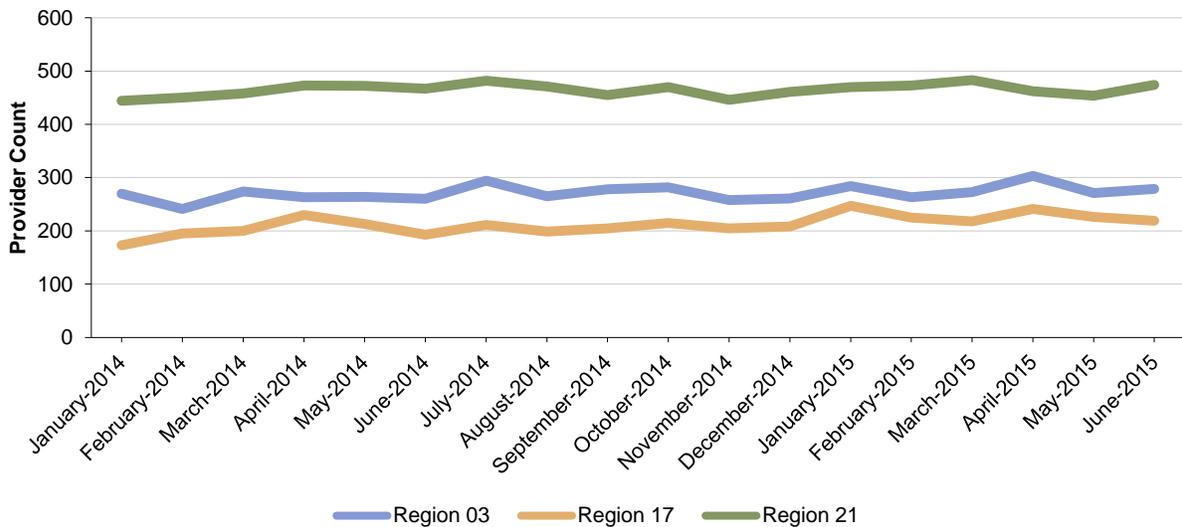


Figure 80 - Physician Specialist Services provider count, HSRs 03, 17, 21

Similar trends can be observed in regard to the provider count, which showed a larger number of providers in Region 21 as compared to that of Regions 03 and 17. All three HSRs showed increasing provider counts.

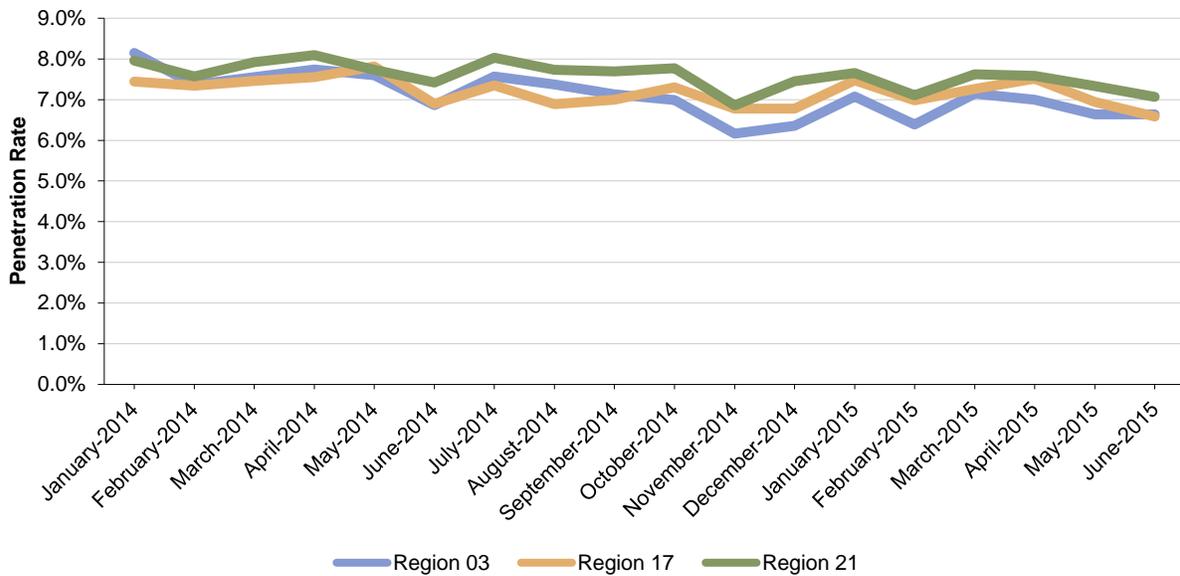


Figure 81 - Physician Specialist Services penetration rate, HSRs 03, 17, 21

Despite the large variation in the utilizer and provider count, it appears that the penetration rate was relatively similar for all regions. While there appears to be a decrease in penetration beginning in early 2015, the slight decrease is not concerning.

Analysis for HSRs 03, 17, and 21

The fluctuations in utilizer and provider counts increased and decreased in alignment with one another. The data on utilizer and provider count in Regions 03 and 07 demonstrates minimal fluctuation, and both utilizer counts and provider counts steadily increased in the two regions over the 18 months measured.

Penetration rates for all three regions were similar to the fluctuations that can be seen in utilizer and provider counts, with the ebb and flows of the penetration rates mirroring the same.

Based on the relatively stable trend lines and high utilization across all three regions, the data does not appear to indicate an access issue.

Physician Specialist Services Analysis by Provider Type and Place of Service

Figure 82 is a FY 2014-15 snapshot of Billing Provider type by utilizer count. This depicts the distribution of billing provider types within the service category who deliver the benefit. *Fulfills requirement 42 CFR 447.203(b)(1)(ii)*

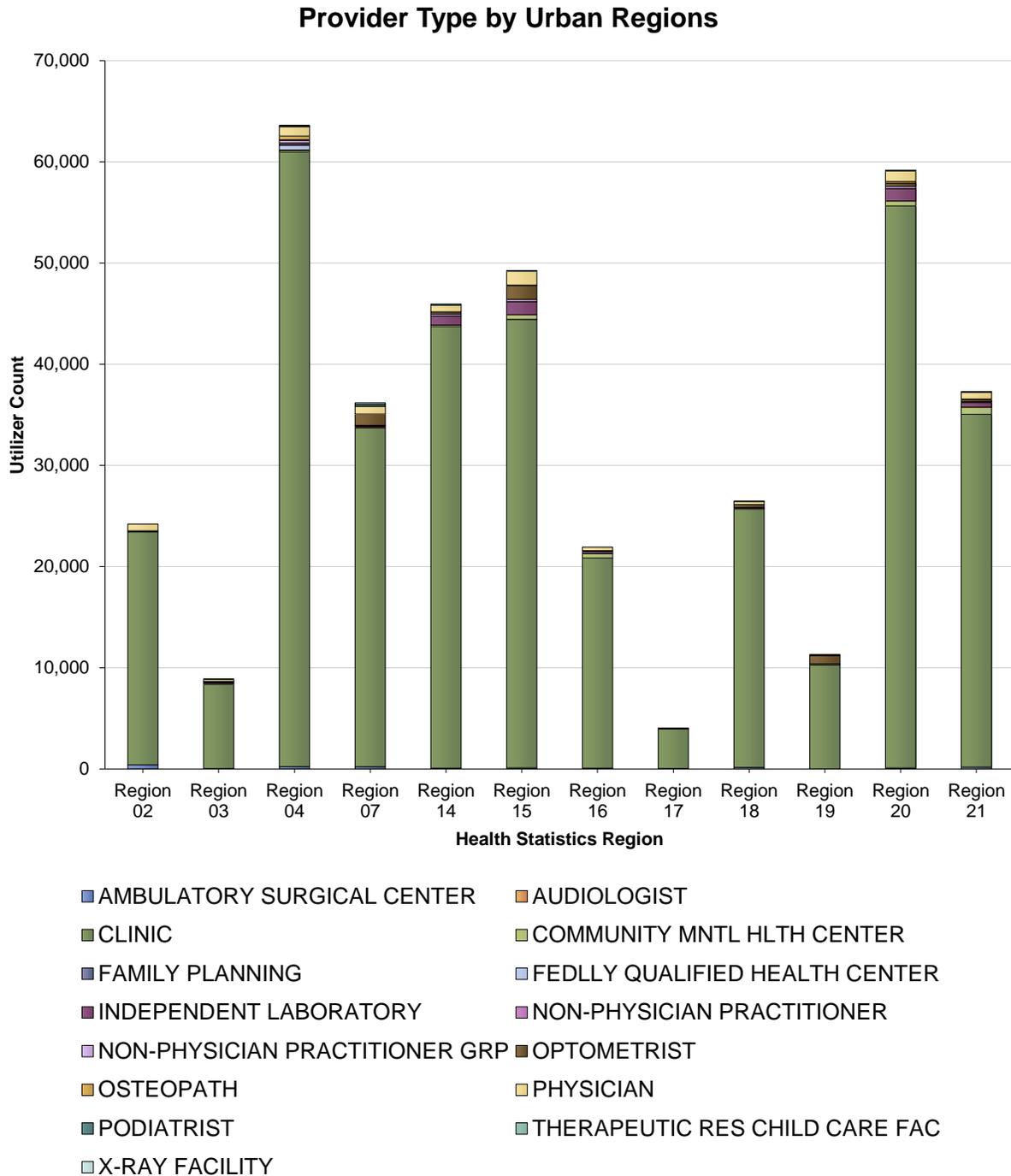
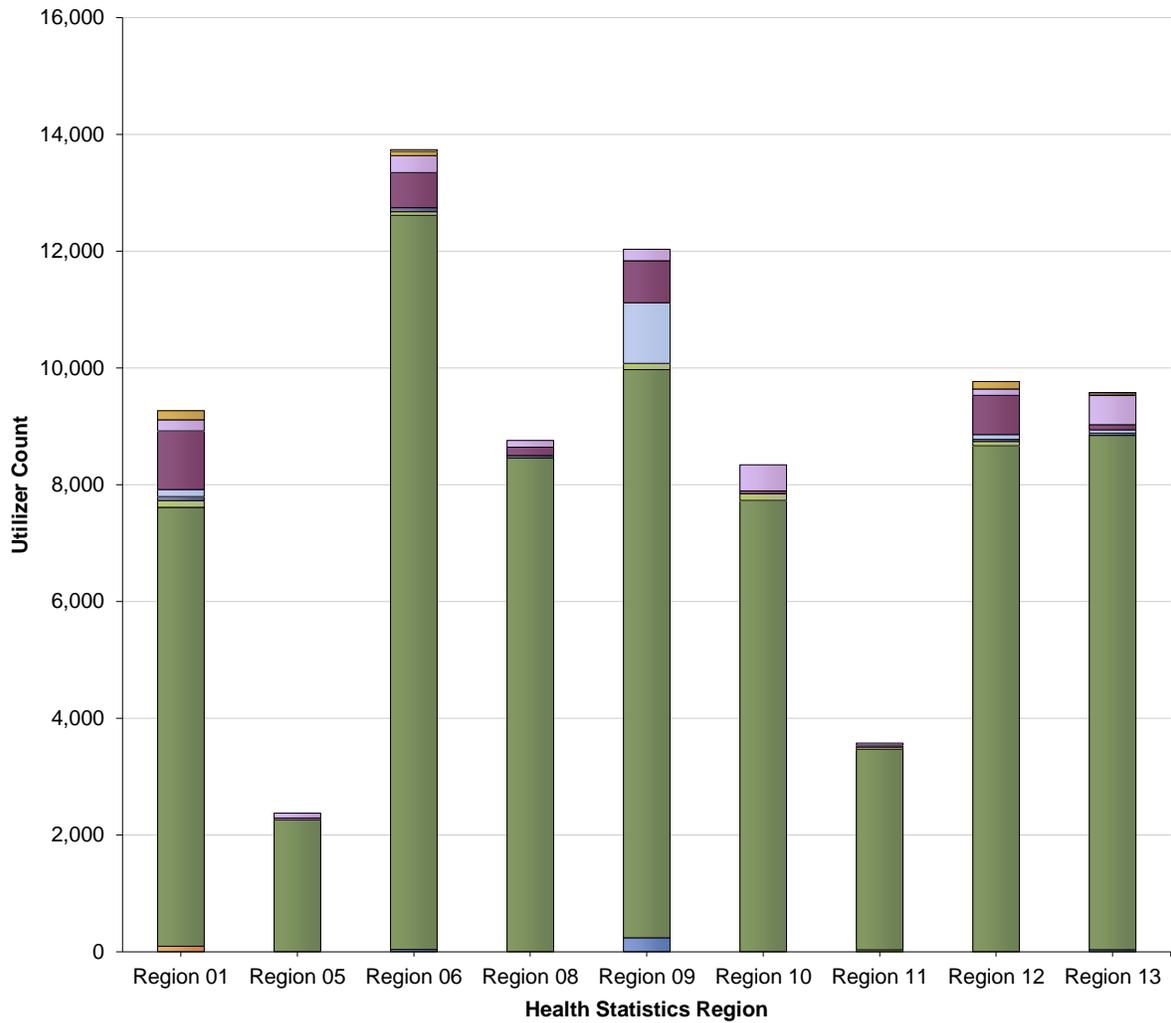


Figure 82 - Physician Specialist Services provider type by urban HSRs

Provider Type by Rural Regions



- AMBULATORY SURGICAL CENTER
- AUDIOLOGIST
- CLINIC
- COMMUNITY MNTL HLTH CENTER
- INDEPENDENT LABORATORY
- NON-PHYSICIAN PRACTITIONER GRP
- OPTOMETRIST
- OSTEOPATH
- PHYSICIAN
- PODIATRIST
- RURAL HEALTH CLINIC
- X-RAY FACILITY

Figure 83 - Physician Specialist Services provider type by rural HSRs

Analysis for Provider Type

Urban HSR Analysis

Physician Specialist Services are delivered by a variety of provider types consistently across all the urban HSRs. The vast majority of specialty service utilizers across the State received services from physicians working within a physician group (using clinic provider type on claims). The next most common provider types were individual physicians and independent laboratories. Optometrists made up a relatively small portion of utilization, serving members mostly in regions 07, 14, 15, 20, and 21 (Pueblo and the Front Range counties surrounding the Denver metro area).

Rural HSR Analysis

Similar to the urban HSRs, specialty service utilizers in rural HSRs received services from physicians that are part of a physician group (clinic provider type on claims). After physician groups, optometrists served the next group of patients. Strikingly, non-physician practitioners were a common provider type in Region 09 (the southwest corner of the State).

Figure 84 is a FY2015 snapshot of Place of Service by utilizer count. This depicts the distribution of place of service (the setting where the benefit was delivered) within the service category. *Fulfills requirement 42 CFR 447.203(b)(1)(ii)*

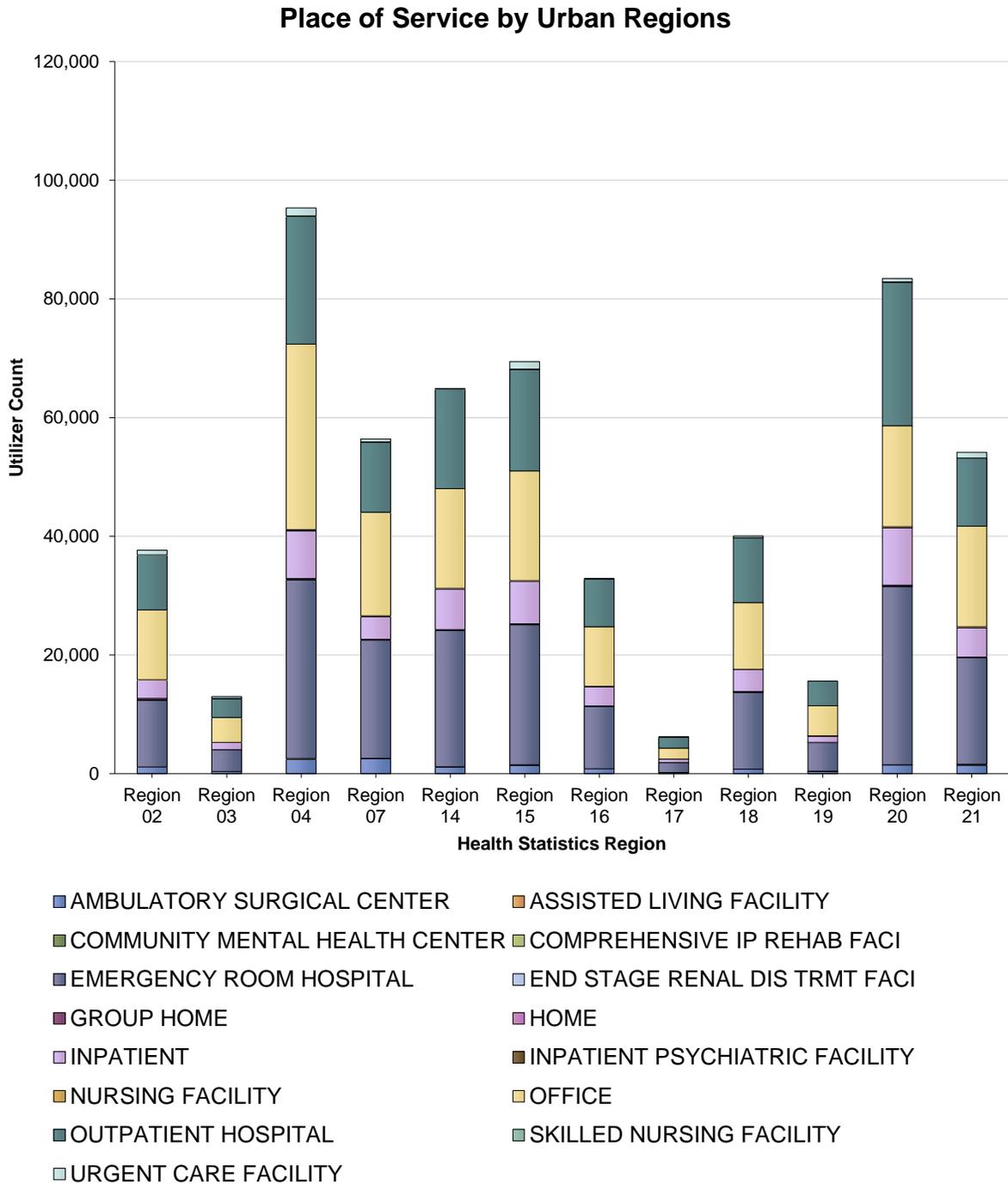


Figure 84 - Physician Specialist Services place of service by urban HSRs

Place of Service by Rural Regions

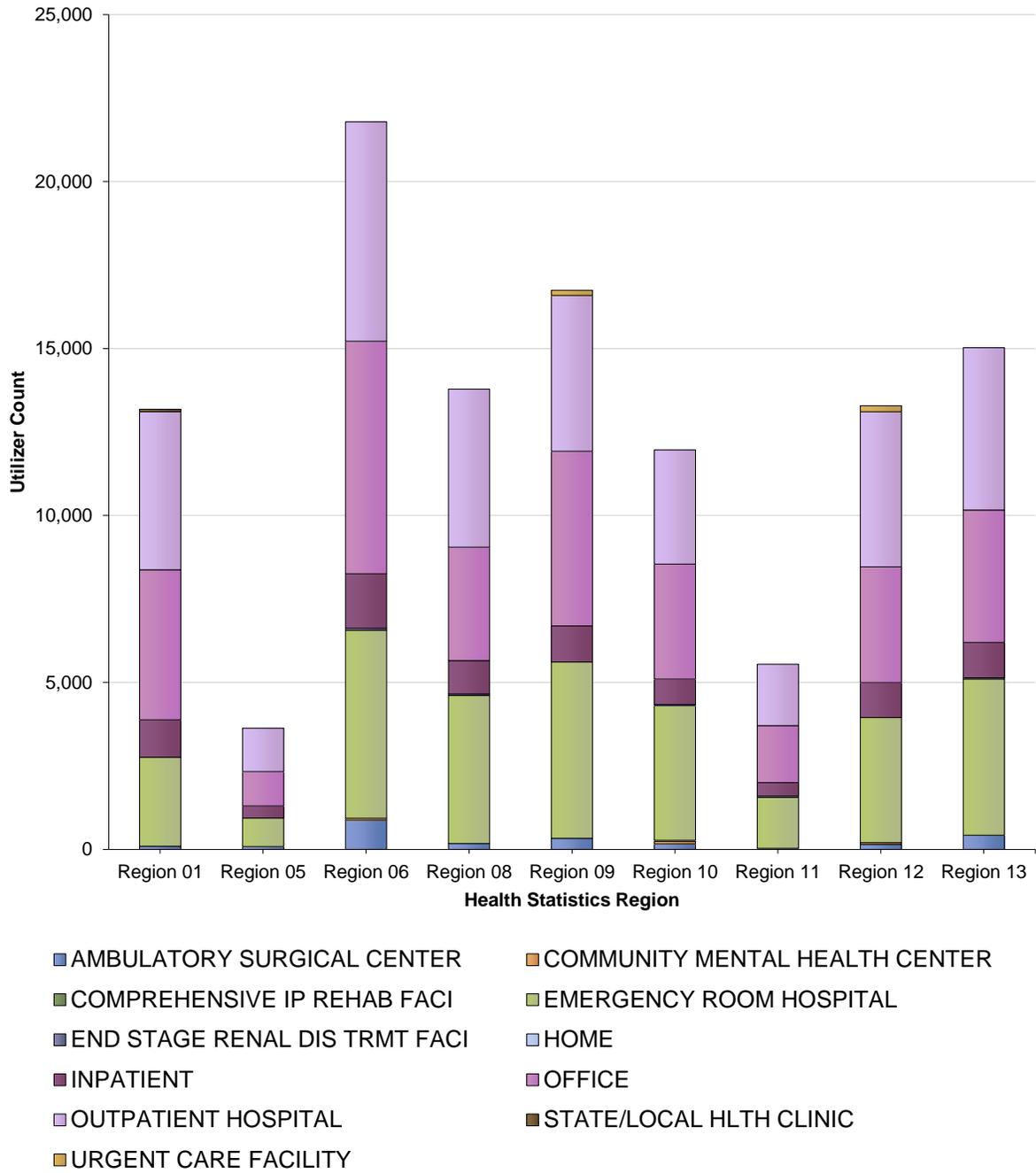


Figure 85 - Physician Specialist Services place of service by rural HSRs

Analysis of Place of Service

Urban HSR Analysis

In urban areas, utilizers most commonly received their specialty care in emergency rooms. The second and third most common places of service were in outpatient hospital departments and provider offices. Region 20 (Denver) and Region 04 (El Paso county – Colorado Springs) have a high number of emergency hospital departments, thus it is not surprising for high utilization to show up in the data. The Department is dedicated to promoting preventive care and services in settings other than the emergency rooms. Staff will monitor emergency room utilization data to better inform Physician Specialist Services access initiatives.

Rural HSR Analysis

Similar to urban areas, a lot of utilizers accessed care in emergency rooms. Provider offices and outpatient hospital departments were common places of services as well. Emergency room visits were particularly high in Region 07, and the Department will work with local providers to promote appropriate utilization and access to primary care in this region.

Physician Specialist Services Colorado Health Access Survey Data

The following metrics from the Colorado Health Access Survey were used to further investigate access to care.

Visited a specialist in the last 12 months

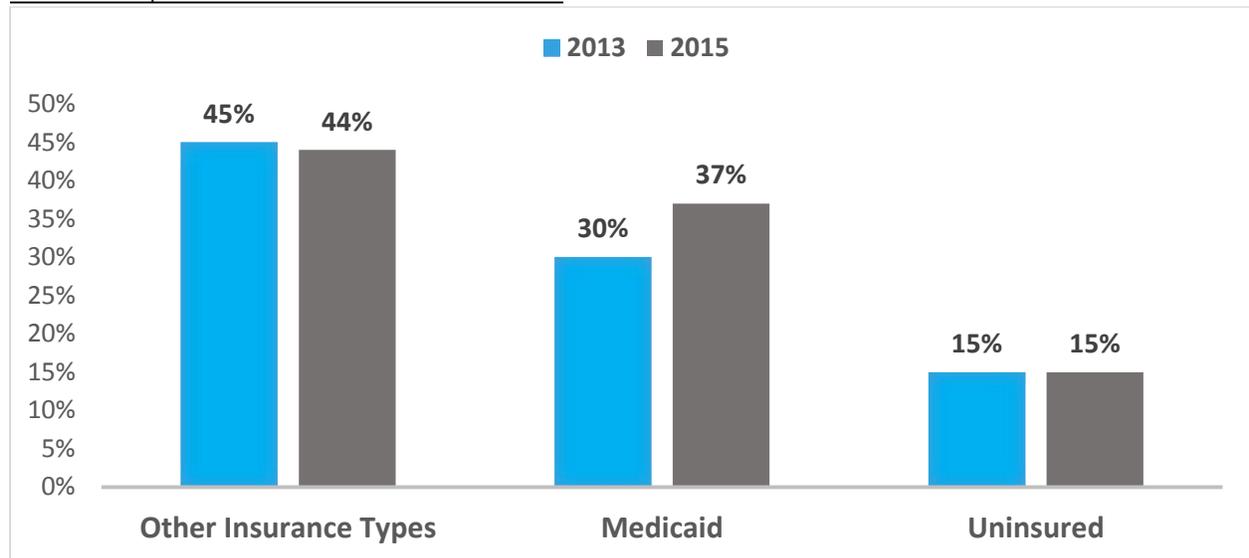


Figure 86 - Physician Specialist Services percentage of participants who visited a specialist in the last 12 months, by coverage type

Analysis for: 'Visited a specialist in the last 12 months'

The percentage of Medicaid members surveyed who visited a specialist grew from 2013 to 2015; this growth is statistically significant. By comparison, access for individuals with other insurance types was reported to have remained the same in 2015 and may have decreased. In 2015, Medicaid members were not significantly more or less likely to see a specialist than other insured Coloradans. While Medicaid members were less likely to visit a specialist than those of other insurance types, this

difference could be attributable to factors other than access issues, such as cultural mistrust of the health care system at large which might affect an individual’s decision to seek services. This metric must be evaluated in the context of all data gathered.

Told doctor wasn’t accepting insurance type

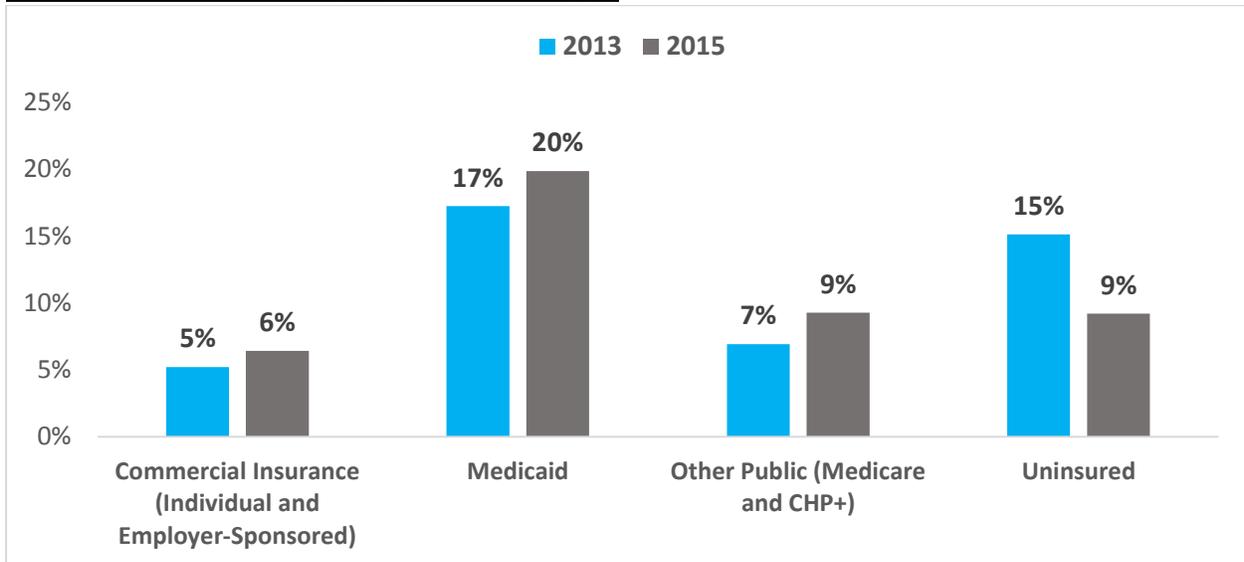


Figure 87 - Physician Specialist Services percentage of participants who were told that a doctor wasn't accepting insurance type, by coverage type

Analysis for: ‘Told doctor wasn’t accepting insurance type’

The percentage of Medicaid members surveyed who said they were told by a doctor that they weren't accepting Medicaid patients grew from 2013 to 2015, but this difference was not statistically significant. In 2015, Medicaid members were significantly more likely to have trouble finding a provider who accepts their insurance than other insured Coloradans. This metric alone does not necessarily indicate an access issue and must be evaluated in the context of all data gathered.

Physician Specialist Services Rate Comparison – Actual or Estimated Levels of Provider Payment

Fulfills requirement 42 CFR 447.203(b)(1)(v)

In aggregate, the 2016 Health First Colorado rates for Physician Specialist Services varied by place of service based on the top 50 procedure codes used to bill for services. Of the top 50 codes, the Department identified at least 10 Medicaid and private payer codes in the CIHVC data (from the Colorado All Payer Claims Database) that matched and could be used comparative analysis. Available Medicare codes did not differentiate by place of service, therefore the average of all top codes for all places of service was used for comparative analysis.

This table displays the percentage Medicaid rates differ from private payers (CIVHC difference) and Medicare. . For example, Medicaid rates are 5.69% below Medicare. The wide difference in CIVHC rate percentages below reflects the different codes that were both available and were most commonly used. Each place of service had different commonly used codes available. These rate comparisons are made at the aggregate level and do not drill down to the specific procedure code level.

Place of Service	CIVHC % Difference	MEDICARE % Difference
Office	-26.56%	5.69%
Urgent care facility	-6.83%	5.69%
Inpatient hospital	233.96%	5.69%
Outpatient hospital	-16.57%	5.69%
Emergency room -- hospital	-15.63%	5.69%
Ambulatory surgical center	12.05%	5.69%
Nursing facility	169.35%	5.69%
Custodial care facility	219.26%	5.69%
Hospice	17.36%	5.69%
Independent clinic	31.80%	5.69%
Community mental health center	33.50%	5.69%
Public health clinic	161.59%	5.69%
Rural health clinic	-4.15%	5.69%
Other place of service	-81.34%	5.69%
AVERAGE	51.99%	5.69%

Table 7 - Physician Specialist Services rate comparison table

Physician Specialist Services Input from Beneficiaries, Providers, and Stakeholders Fulfills requirement 42 CFR 447.204(a)(2)

Fulfills requirement 42 CFR 447.204(b)(3) – as applicable under ‘Specific Analysis of Input from Stakeholders Affected by a Payment Restructure or Reduction’

Physician Specialist Services Direct-to-Staff Input

Department staff does receive localized concerns about access to specialty services directly from beneficiaries, providers, and stakeholders while performing their operational duties. Staff investigate and address those concerns in accordance with the procedures detailed in the Access Monitoring Review Plan – Appendix A.

Another mechanism used to track stakeholder feedback and potential access deficiencies is our Customer Contact Center (CCC), which documents and reports data for each member interaction. Refer to page 73 of this Plan to view HSRs which have a higher volume of complaints that are - or could potentially be - access related.

Physician Specialist Services Targeted Stakeholder Input and Input from General Public Notice

A draft of this Plan was sent to key stakeholders and was made publicly available on the Department’s website for 30 day public comment. Feedback and input was accepted through email and through an online survey and is summarized in Appendix K. Several stakeholders pointed to anomalies in the way the data and analysis above was originally presented. Where applicable, the Department has clarified.

Several stakeholders shared anecdotal evidence not found in the claims data that access to specialty care is inadequate. Stakeholders cited their own service-specific and regional (HSRs 16 and 19) data and experience. The stakeholder group who asserted that Individuals with disabilities experience access issues to Primary Care Services, also asserted the same with regard to Physician Specialist Services.

The Department's access analysis above identified areas of the State that require further research over time to understand atypical utilization trends, including HSRs 16 and 19. The Department will continue to monitor utilization and access patterns in these regions.

Physician Specialist Services Access Issues Discovered As a Result of This Review *Fulfills requirements 42 CFR 447.203(b)(4)*

This is a list of the Access Issues identified using the data available in this review. Data which suggests an Access Issue will be investigated and monitored for a period of two consecutive quarters to ensure the pattern is not an artifact or data anomaly. If investigation does reveal a deficit, the Access Issue becomes an Access Deficiency which triggers the process described in the Access Monitoring Review Plan – Appendix B (42 CFR 447.203(b)(8)).

No access issues were identified as a result of this review, however certain trends warrant further investigation. Staff have become aware of certain regions that should be closely monitored. Region 19's penetration rate has dropped over the past year while provider count has remained steady. This is likely caused by the transition to a managed care plan in the region, and the data used for this analysis is not inclusive of managed care plans. The result is that, while it appears that access has diminished, in all likelihood, it is not truly the reality. In addition, during the public comment phase of this Plan, the Department received feedback that there may be an access issue for specialty services in HSR 16. These regions will be investigated further and reported on in the next version of the Plan.

In addition, the review has shed light on the periodic fluctuations in Medicaid. Across the State, utilization count, provider count, and penetration rates tended to increase in April and August and drop in November of each year. Understanding the monthly changes will help the Department identify potential issues in the future.

Physician Specialist Services Extent to Which Beneficiary Needs Are Fully Met *Fulfills requirements 42 CFR 447.203(b)(1)(i)*

Medicaid enrollment and member utilization of specialty services fluctuated throughout the year in the majority of health statistical regions. While there were regional differences, member count, provider count, and penetration rates tended to increase and decrease similarly. The data demonstrated that the majority of members received specialty care services in outpatient settings, particularly in emergency rooms. The Department is dedicated to promoting preventive services and community based access to physician specialists to avoid unnecessary emergency room visits and inpatient stays. The data confirms the importance of engaging provider networks to encourage appropriate utilization. There were some regions of the State in which the data indicated need for close monitoring, but the data does not indicate an access issue in these areas at this time.

The Department acknowledges the CHAS sampling data concerning member difficulty finding a specialty provider. This sample survey data does not necessarily agree with administrative claims data for the entire population, which reveals steady utilization rates and, usually, increasing levels of active specialty service providers. For example, in HSR 04 (El Paso county), the number of active physician specialists increased 25%, from 320 in January 2014 to 401 in June 2015. For the Department to draw the conclusion that access to specialty services, in general, is insufficient, while factoring in data that provider counts generally increased, would be inappropriate.

The Department's analytical conclusion is that Physician Specialist Services are sufficient to enlist enough providers so that services are available at least to the extent they are available to the general population in each geographic area, pursuant to section 1902(a)(30)(A) of the Social Security Act.

Appendix H: Access Monitoring Analysis - Behavioral Health Services (FFS)

Fulfills requirement 42 CFR 447.203(b)(5)(ii)(C)

Behavioral Health Services (FFS) Definition of Service

This service covers fee-for-service Behavioral Health Services for Medicaid members who are: not eligible for enrollment in the Community Behavioral Health Service Program (through the Behavioral Health Organizations, or BHO), which is the Department's managed care delivery system under 1915(b)(3) waiver authority; or for conditions not covered by the BHO system; or some combination of these two factors. As such, the utilization of this service does not reflect access to care for Behavioral Health Services at large but, rather, only measures access for a small sub-population (23,509 utilizers) of the Health First Colorado enrollment pool. Under rare circumstances, members may access this benefit prior to obtaining enrollment in a BHO, or may access this benefit if they have voluntarily opted out of BHO network coverage. When providers treat a member who is not in the BHO network, or the combination of service codes and diagnosis codes is not within the BHO contract for coverage, the claim for the service is paid fee-for-service, through this benefit. Therefore, the trends for utilizer count, provider count, and penetration rate below are not as meaningful for truly measuring access as they are when measuring other service categories. Covered services include mental health and substance use disorder benefits.

Access to care for Behavioral Health Services provided by the BHO network is not analyzed in this report because it is outside the scope of regulatory requirements. The BHOs have a robust regulatory framework for ensuring, and reporting, sufficient access to care.

Behavioral Health Services (FFS) Characteristics of the Beneficiary Population

Fulfills requirements 42 CFR 447.203(b)(1)(iv)

Available services and payments do not vary for member populations or geographic locations throughout the State. Most utilizers are adult females between the ages of 35 and 64, similar to the makeup of Physician Specialist Services. Members access this benefit by visiting a behavioral health provider, usually at a Community Mental Health Center.

Behavioral Health Services (FFS) Administrative Claims Utilization Data

Figure 88 is a FY 2014-15 snapshot of demographic groups (children/adults/individuals with disabilities) by utilizer count. This depicts the demographic group distribution of service utilizers, which informs the Beneficiary Characteristic description. *Fulfills requirement 42 CFR 447.203(b)(1)(iv)*

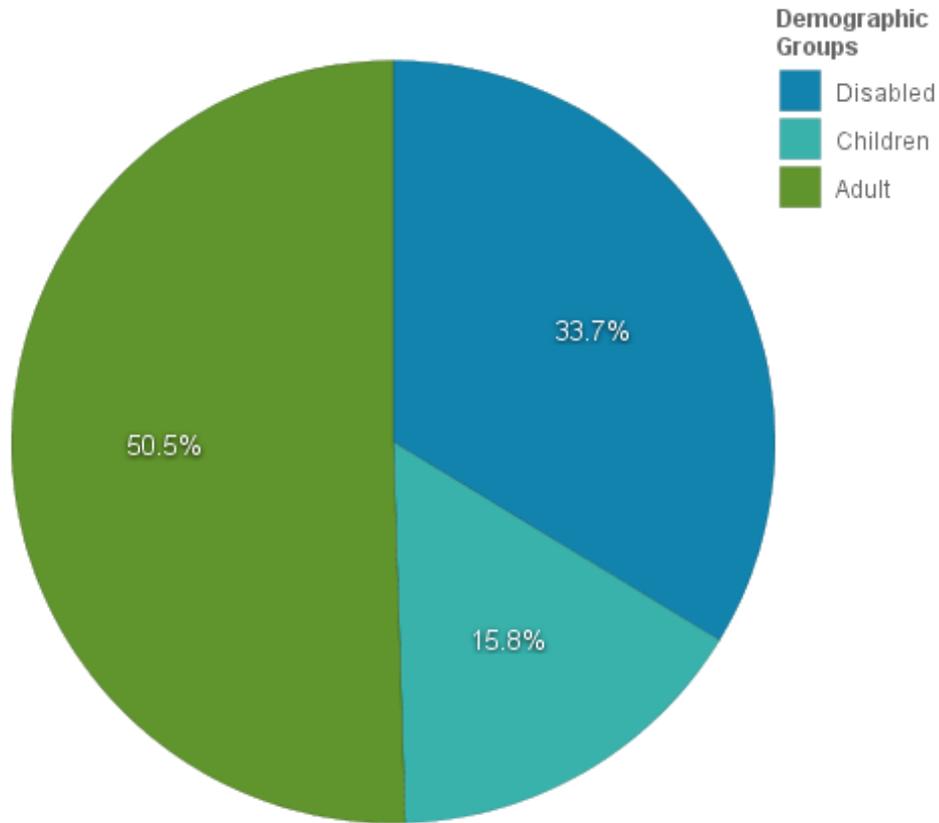


Figure 88 – Behavioral Health Services (FFS) percentage of utilizers, by demographic groups

Analysis of Demographic Groups:

Given the nature of the population that utilizes Behavioral Health Services (FFS) in Colorado, this statistic does not provide insight into the adequacy of access to care.

Figure 89 is a FY 2014-15 snapshot of gender groups by utilizer count. This shows the gender distribution of service utilizers. *Fulfills requirement 42 CFR 447.203(b)(1)(iv)*

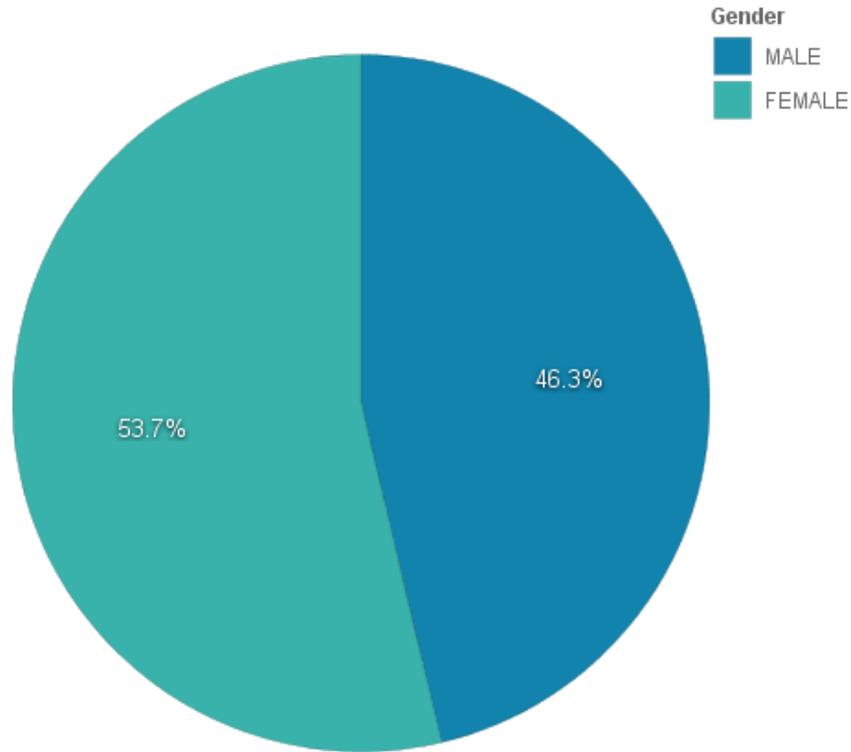


Figure 89 - Behavioral Health Services (FFS) percentage utilizers, by gender

Analysis of Gender Groups:

Given the nature of the population that utilizes Behavioral Health Services (FFS) in Colorado, this statistic does not provide insight into the adequacy of access to care.

Figure 90 is a FY 2014-15 snapshot of age groups by utilizer count. This depicts the age distribution of service utilizers. *Fulfills requirement 42 CFR 447.203(b)(1)(iv)*

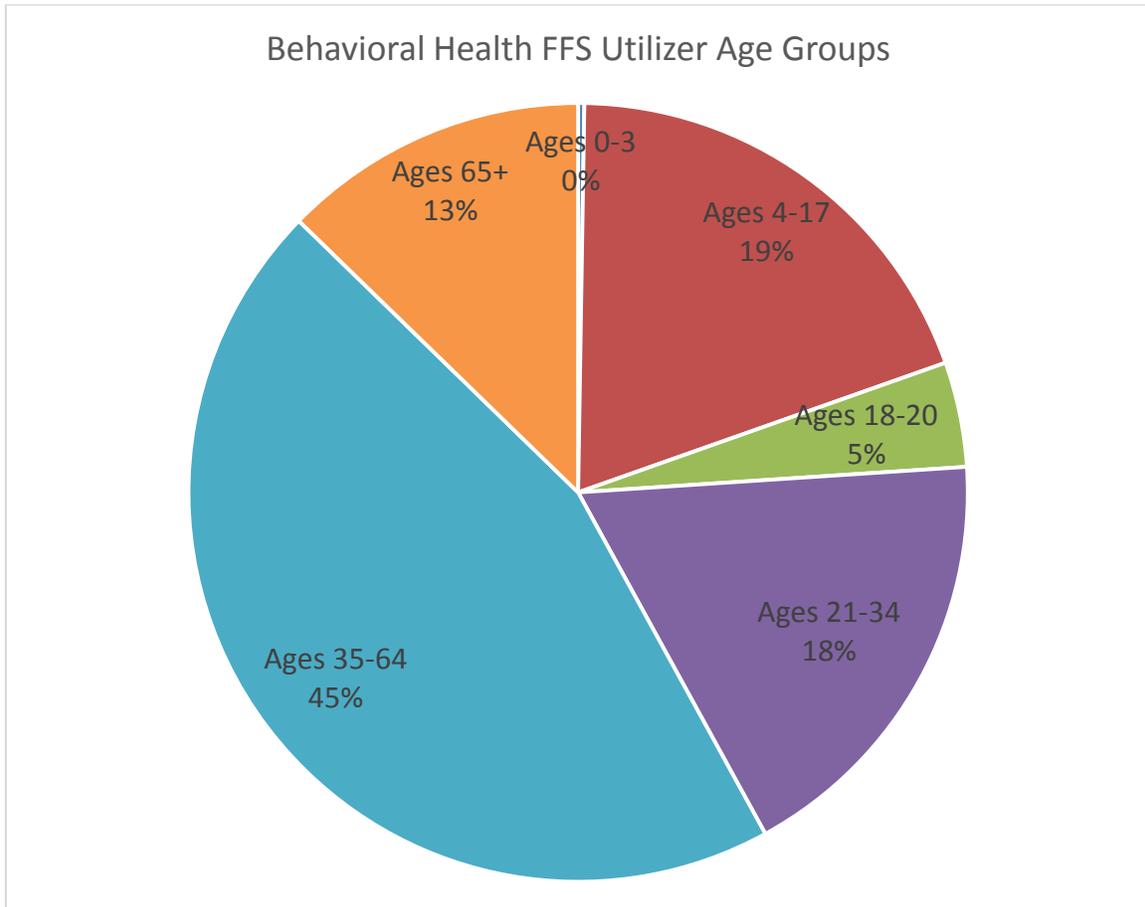


Figure 90 - Behavioral Health Services (FFS) percentage utilizers, by age

Analysis of Age Groups:

Given the nature of the population that utilizes Behavioral Health Services (FFS) in Colorado, this statistic does not provide insight into the adequacy of access to care.

Table 8 is a FY 2014-15 snapshot of top 10 diagnoses by utilizer count, further broken out by demographic group. It includes what percentage of total service utilizers each demographic group constituted. This characterizes the needs of the beneficiary population. *Fulfills requirement 42 CFR 447.203(b)(1)(iv)*

Top 10 Root Diagnosis Codes		
Rank: 1 Principal Diagnosis 296		
Code Description EPISODIC MOOD DISORDERS		
Total Members: 3,660		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	1,565	42.8%
Children	435	11.9%

Individuals with Disabilities	1,660	45.4%
Rank: 2 Principal Diagnosis 305		
Code Description NONDEPENDENT ABUSE OF DRUGS		
Total Members: 2,002		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	1,721	86.0%
Children	115	5.7%
Individuals with Disabilities	166	8.3%
Rank: 3 Principal Diagnosis 309		
Code Description ADJUSTMENT REACTION		
Total Members: 1,558		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	626	40.2%
Children	456	29.3%
Individuals with Disabilities	476	30.6%
Rank: 4 Principal Diagnosis 295		
Code Description SCHIZOPHRENIC DISORDERS		
Total Members: 1,509		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	Blinded	
Children	Blinded	
Individuals with Disabilities	1,012	67.1%
Rank: 5 Principal Diagnosis 311		
Code Description DEPRESSIVE DISORDER NEC		
Total Members: 1,167		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	652	55.9%
Children	117	10.0%
Individuals with Disabilities	398	34.1%
Rank: 6 Principal Diagnosis 300		
Code Description ANXIETY DISSOCIATIVE SOMATOFORM DISORDER		
Total Members: 1,130		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	526	46.5%
Children	119	10.5%
Individuals with Disabilities	485	42.9%
Rank: 7 Principal Diagnosis 780		

Code Description GENERAL SYMPTOMS		
Total Members: 1,076		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	609	56.6%
Children	58	5.4%
Individuals with Disabilities	409	38.0%
Rank: 8 Principal Diagnosis V40		
Code Description MENTAL & BEHAVIORAL PROBLEMS		
Total Members: 1,040		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	Blinded	
Children	773	74.3%
Individuals with Disabilities	Blinded	
Rank: 9 Principal Diagnosis 303		
Code Description ALCOHOL DEPENDENCE SYNDROME		
Total Members: 939		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	849	90.4%
Children	Blinded	
Individuals with Disabilities	Blinded	
Rank: 10 Principal Diagnosis V62		
Code Description OTHER PSYCHOSOCIAL CIRCUMSTANCES		
Total Members: 622		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	289	46.5%
Children	194	31.2%
Individuals with Disabilities	139	22.3%

Table 8 - Behavioral Health Services (FFS) top 10 root diagnosis, by utilizer count

Analysis of Top 10 Diagnoses:

Many items are ‘blinded’ due to Health Insurance Portability and Accountability Act (HIPAA) requirements. Given the nature of the population that utilizes Behavioral Health Services (FFS) in Colorado, this statistic does not provide insight into the adequacy of access to care.

Behavioral Health Services (FFS) Utilization Analysis by Geographic Region

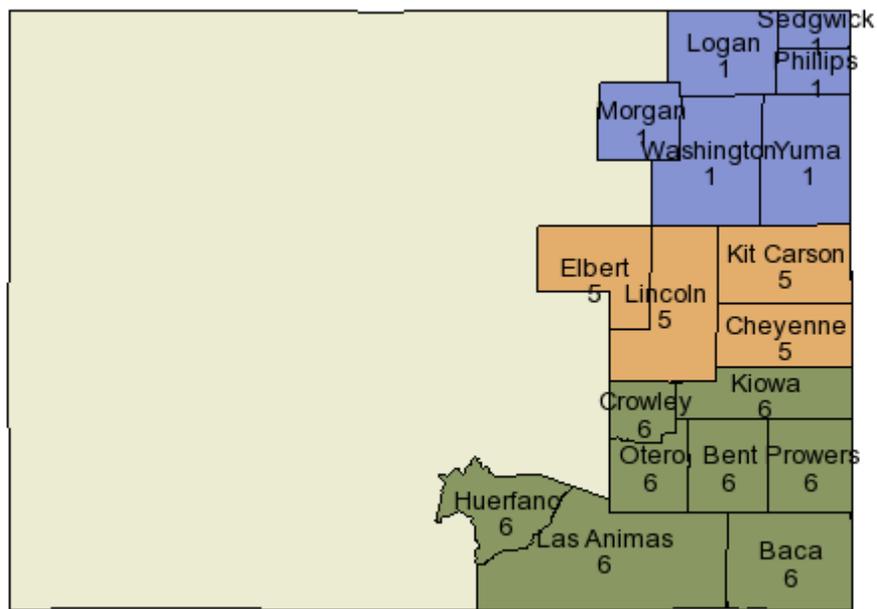
To best review access to health care services for Health First Colorado members, through the lense of administrative claims utilization data, the Department plotted three sets of data points, stratified by each HSR. These were the total volume utilizer count, the active billing provider count, and the service

penetration rate.³¹ What follows is a graphical examination of 18 month trends for each of seven groupings of HSRs. Only the utilization of members for whom Health First Colorado was the payer are shown.

HSRs 01, 05, and 06

Health Statistic Regions 01, 05, and 06 are comprised of residents from the eastern part of the State. These three regions reported approximately 152,000 insured persons in 2013, and grew to approximately 172,000 insured persons by 2015.

Predominately rural, these HSRs account for approximately 3.1% of the State's overall population.



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Figure 91 - Diagram of HSRs 01, 05, 06

³¹ If Medicaid members utilized other services that were paid for by their private insurance or Medicare, that utilization is not captured here.

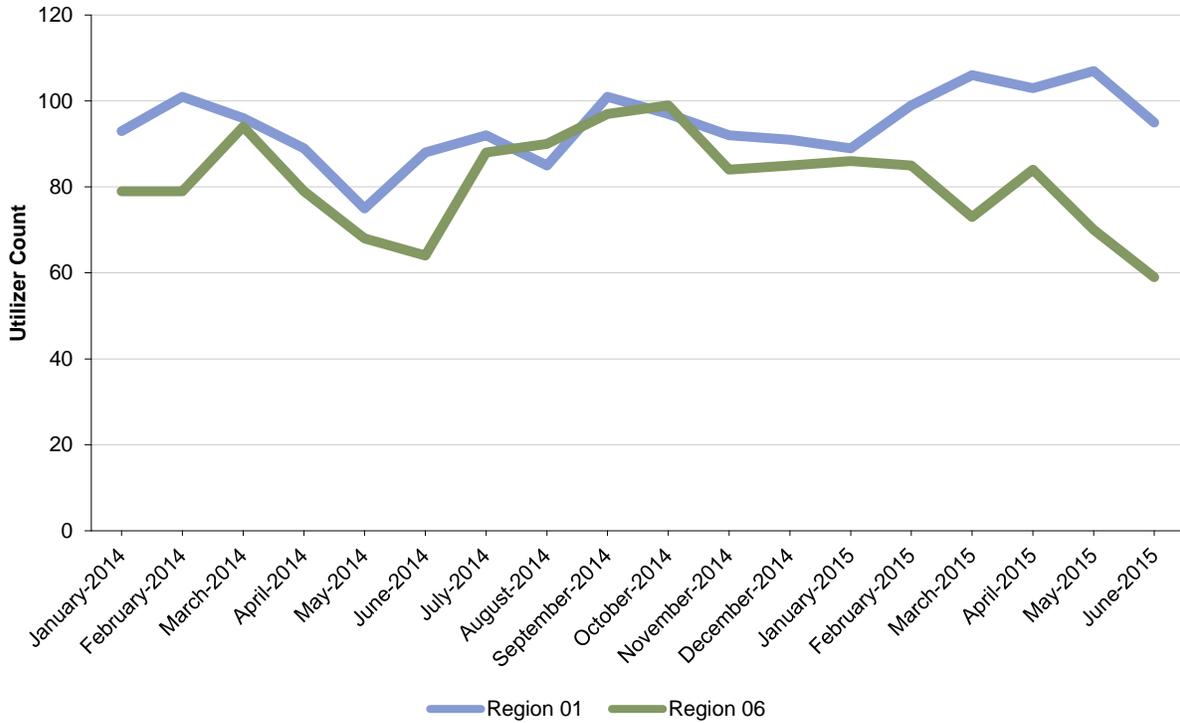


Figure 92 - Behavioral Health Services (FFS) utilizer count, HSRs 01, 06

The utilizer count for Regions 01 and 06 appears to fluctuate year-over-year, with Region 01 reporting slightly larger utilizer counts overall. Data in Region 05 was not available for this measure.

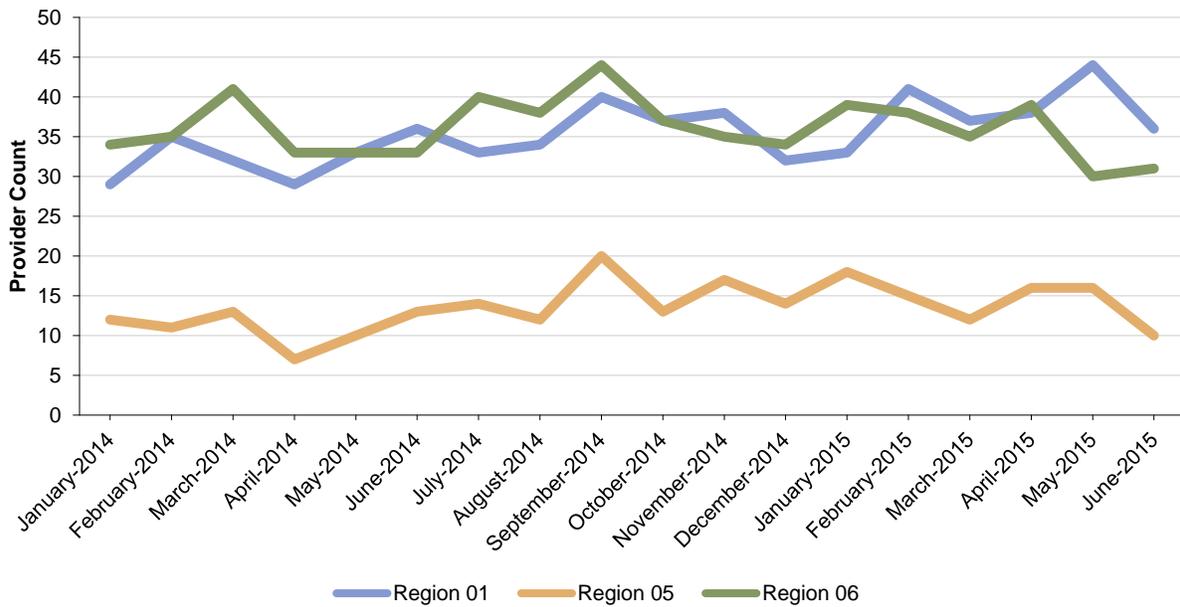


Figure 93 - Behavioral Health Services (FFS) provider count, HSRs 01, 05, 06

The number of providers for Regions 01 and 06 appeared to fluctuate accordingly with utilizer count.

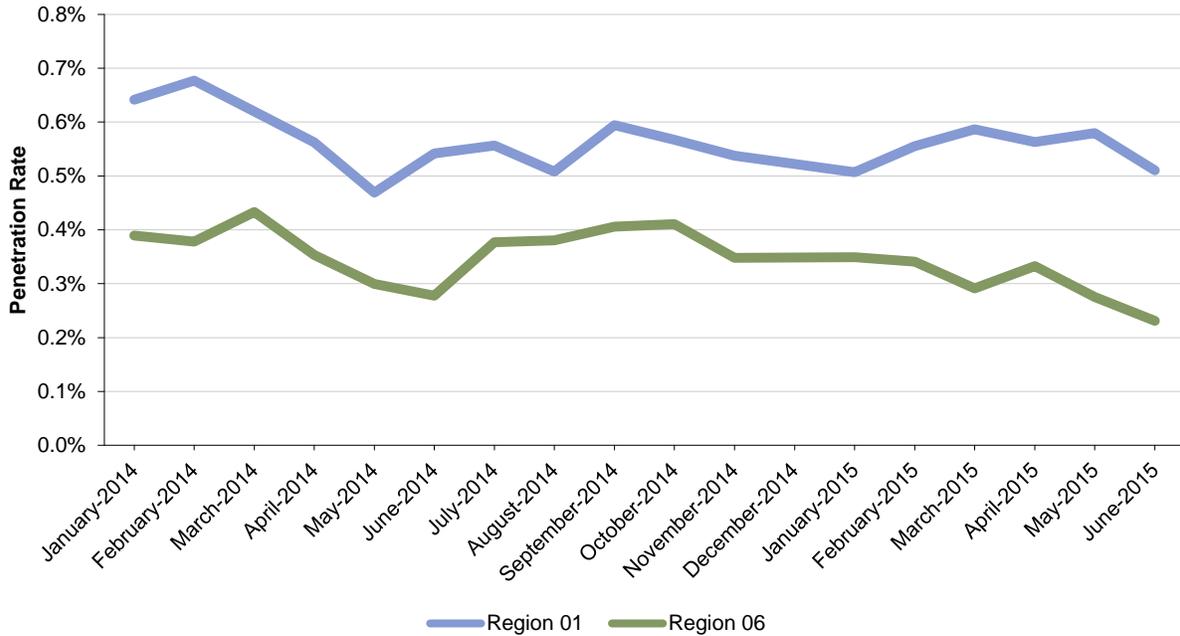


Figure 94 - Behavioral Health Services (FFS) penetration rate, HSRs 01, 06

The penetration rate for these regions appeared to remain relatively stable with slight decreases beginning in March 2015.

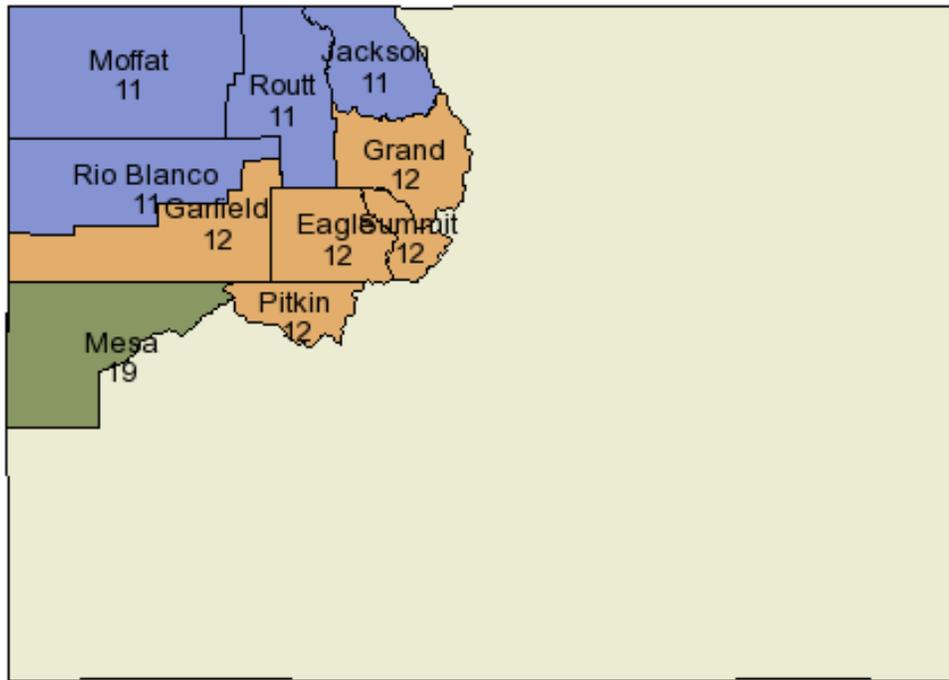
Analysis for HSRs 01, 05, and 6

Trends in Regions 01 and 06 fluctuated periodically. While the penetration rates for each were trending downward as of June 2015, this same shift was observed in 2014. This indicates that such fluctuation may be normal. Taken with the periodic shifts in member and provider count, there is no access issue identified in these HSRs.

HSRs 11, 12, and 19

Health Statistic Regions 11, 12, and 19 are comprised of residents from the north-western part of the State. These three regions reported approximately 297,000 insured persons in 2013, and grew to approximately 321,000 insured persons by 2015.

Predominately rural and mountainous, with one major urban center, these HSRs account for approximately 5.8% of the State's overall population.



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Figure 95 – Diagram of HSRs 11, 12, 19

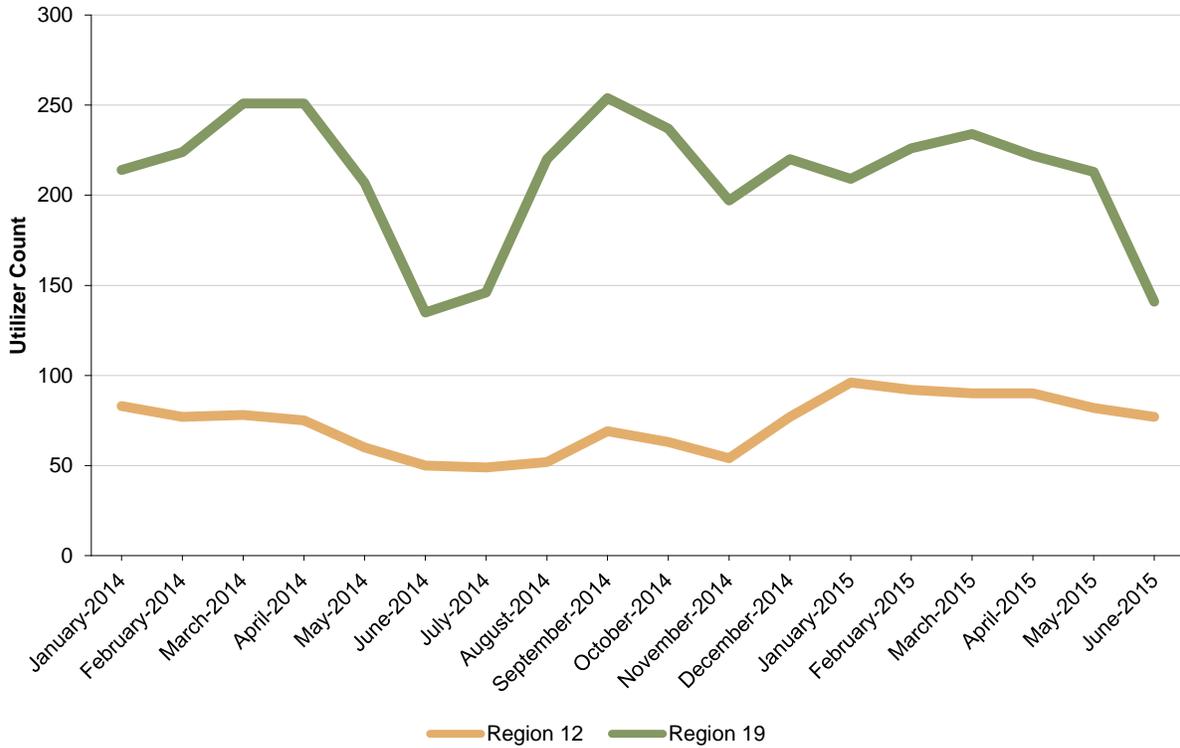


Figure 96 - Behavioral Health Services (FFS) utilizer count, HSRs 12, 19

The utilizer count in Region 19 was higher than that of Region 12. The utilizer count for Region 11 was not available.

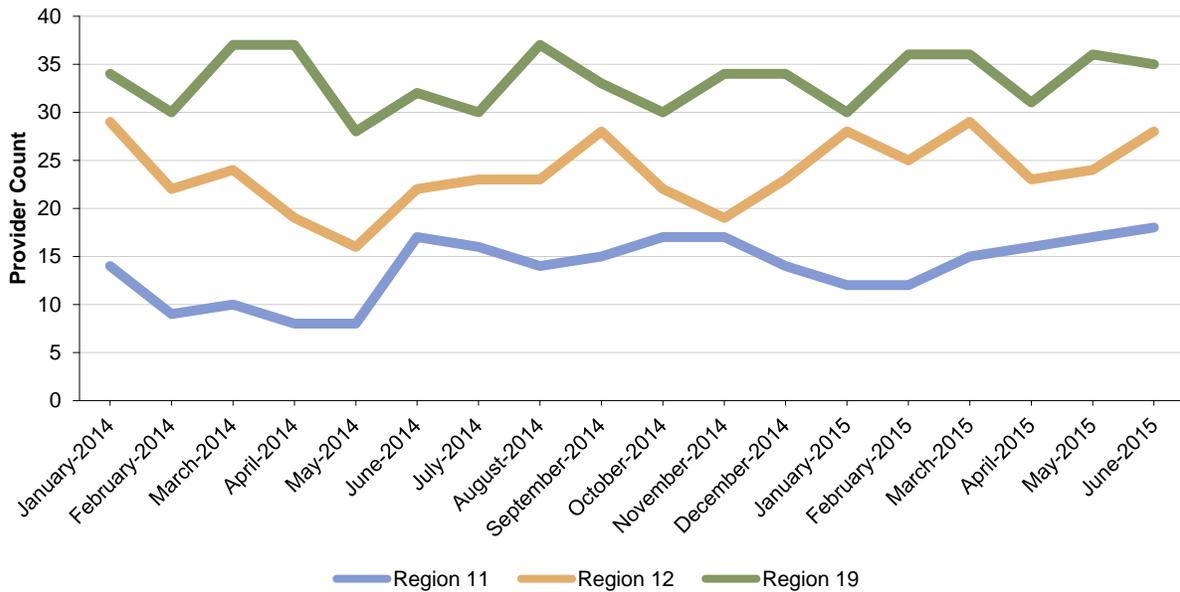


Figure 97 - Behavioral Health Services (FFS) provider count, HSRs 11, 12, 19

The provider count was also higher in Region 19, which makes sense, as the utilizer count was largest in that region as well. The provider count for Region 12 also appears to align to the utilizer count of that region. And, in general, the fluctuation in provider count appears to ebb and flow with the increase and decrease of utilizer counts for each region.

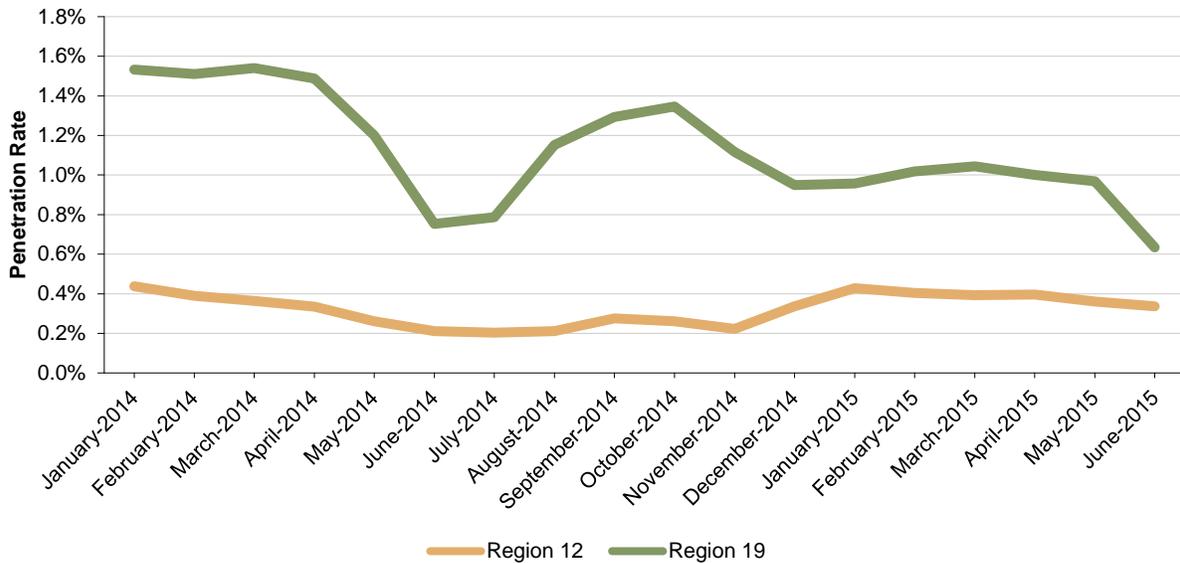


Figure 98 - Behavioral Health Services (FFS) penetration rate, HSRs 12, 19

Penetration rates for these regions appear to mirror utilizer count. Based on the nature of Behavioral Health Services (FFS), this penetration rate appears to be stable given the need of the members in the regions.

Analysis for HSRs 11, 12, and 19

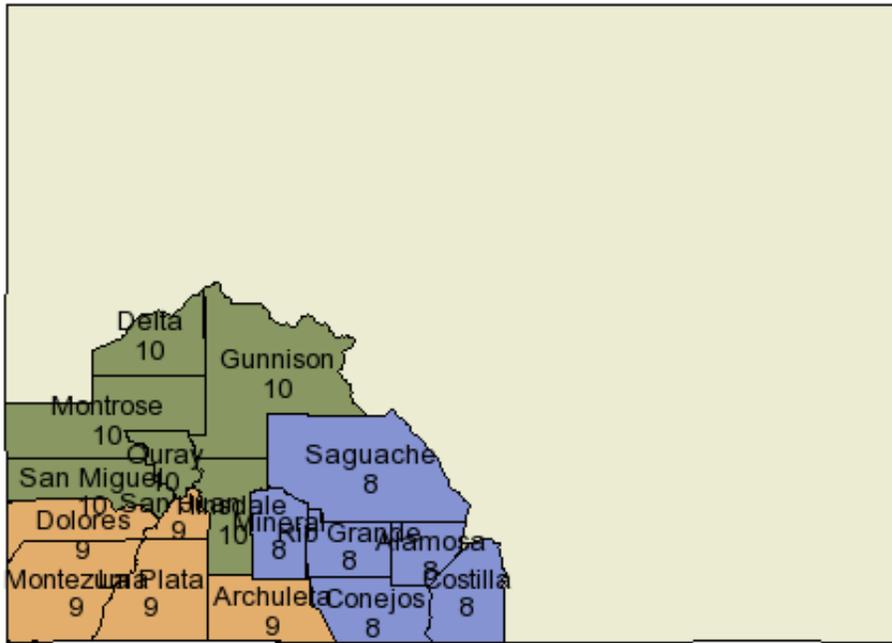
All three regions experienced increases in their active provider counts. The penetration rate in HSR 19 shifted dramatically during the previous 18 months under review, which makes future month trends difficult to predict.

All statistics appear within normal trend variance and do not appear to indicate an access issue.

HSRs 08, 09, and 10

Health Statistic Regions 08, 09, and 10 are comprised of residents from the south-western part of the State. These three regions reported approximately 196,000 insured persons in 2013, and grew to approximately 199,000 insured persons by 2015.

Predominately rural and mountainous, these HSRs account for approximately 3.6% of the State's overall population.



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Figure 99 - Diagram of HSRs 08, 09, 10

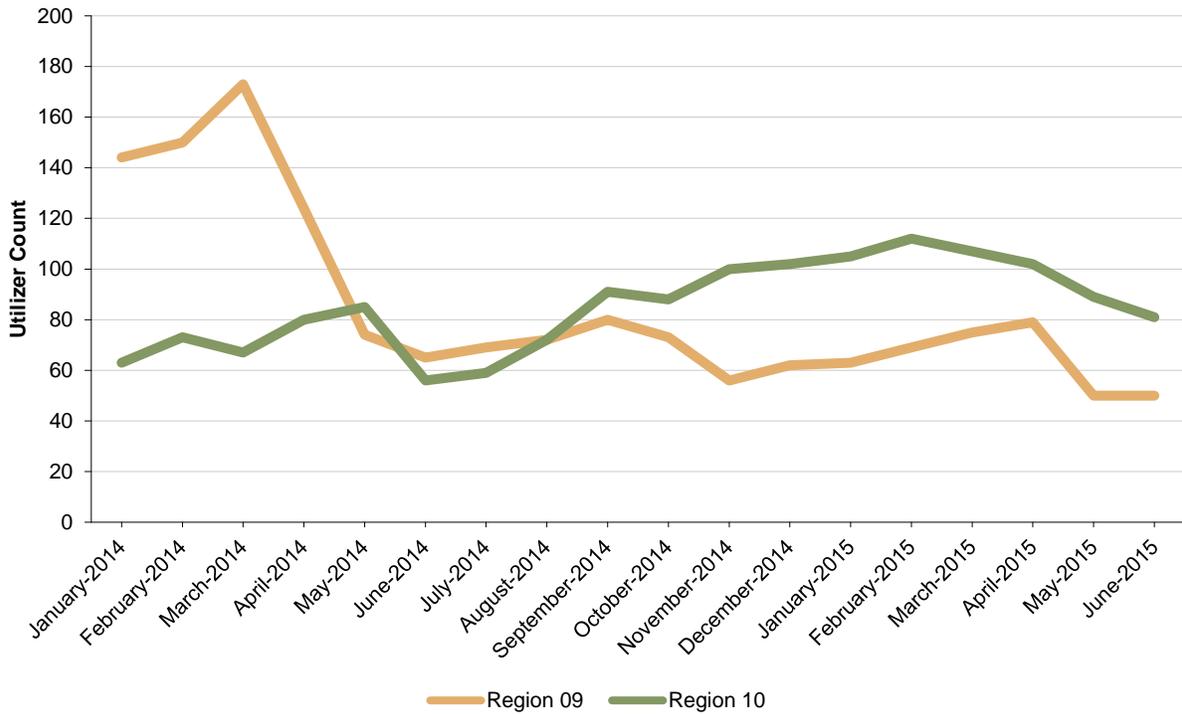


Figure 100 - Behavioral Health Services (FFS) utilizer count, HSRs 09, 10

The utilizer count fluctuated month to month in both regions. HSR 08 had few enough utilizers that the data must be blinded per HIPAA requirements.

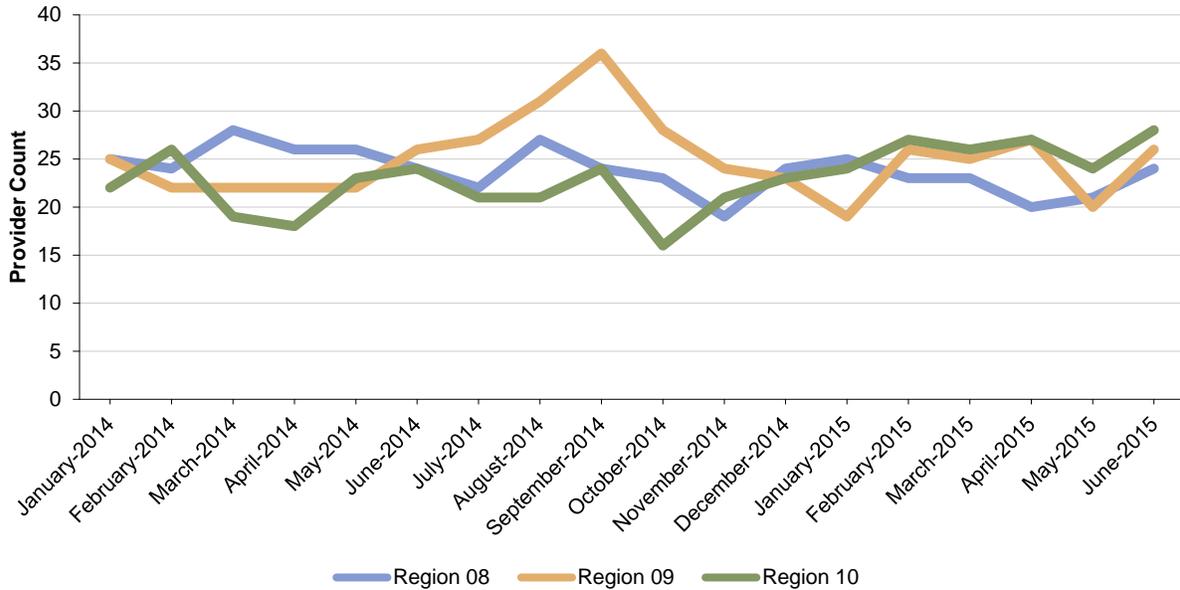


Figure 101 - Behavioral Health Services (FFS) provider count, HSRs 08, 09, 10

The provider count in these HSRs appears to remain relatively stable with a spike in Region 09 during the months of August and October 2014.

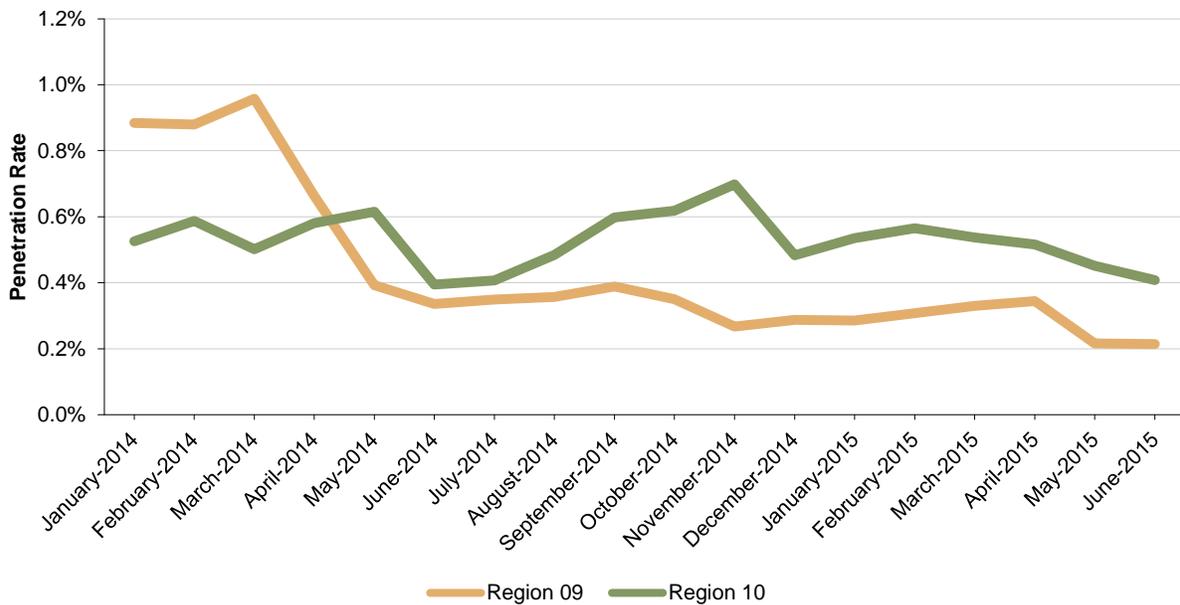


Figure 102 - Behavioral Health Services (FFS) penetration rate, HSRs 09, 10

While penetration rates appear high in the early months of 2014, they appear to fall beginning in June of that year.

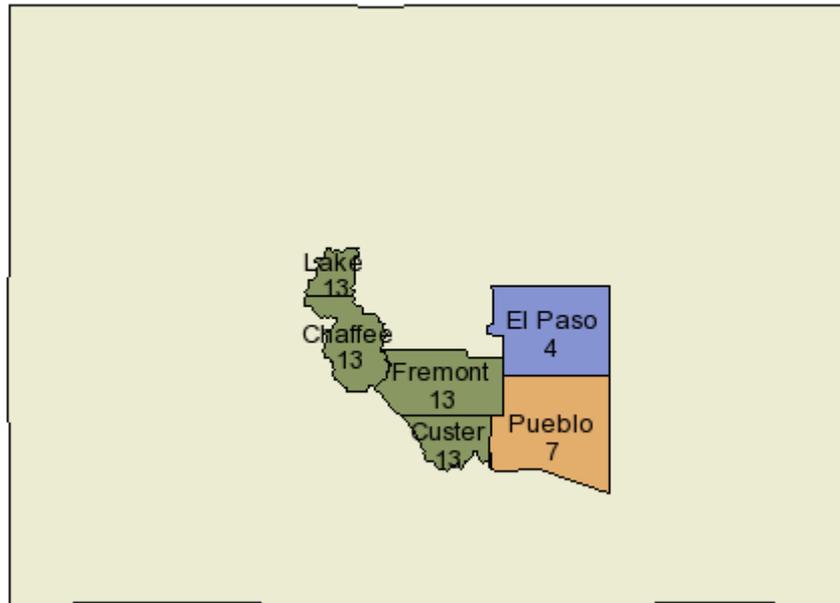
Analysis of HSRs 08, 09, and 10

HSR 09 showed a spike in the utilizer trend in February 2014, then a sudden decline, stabilizing in May 2014. It appears that, each spring, there was a sharp decline of utilizers. The Department does not have an explanation for this trend but it does not appear to be a statistic indicating an access issue because the active provider count has been increasing. Both HSRs 09 and 10 show stable benefit penetration rates beginning calendar year 2015. These statistics do not indicate an access issue.

HSRs 04, 07, and 13

Health Statistic Regions 04, 07, and 13 are comprised of residents in the central to southern part of the State. These three regions reported approximately 750,000 insured persons in 2013, and grew to approximately 800,000 insured persons by 2015.

A mix of urban and rural with some mountainous regions, these HSRs account for approximately 14.6% of the State's overall population.



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Figure 103 - Diagram of HSRs 04, 07, 13

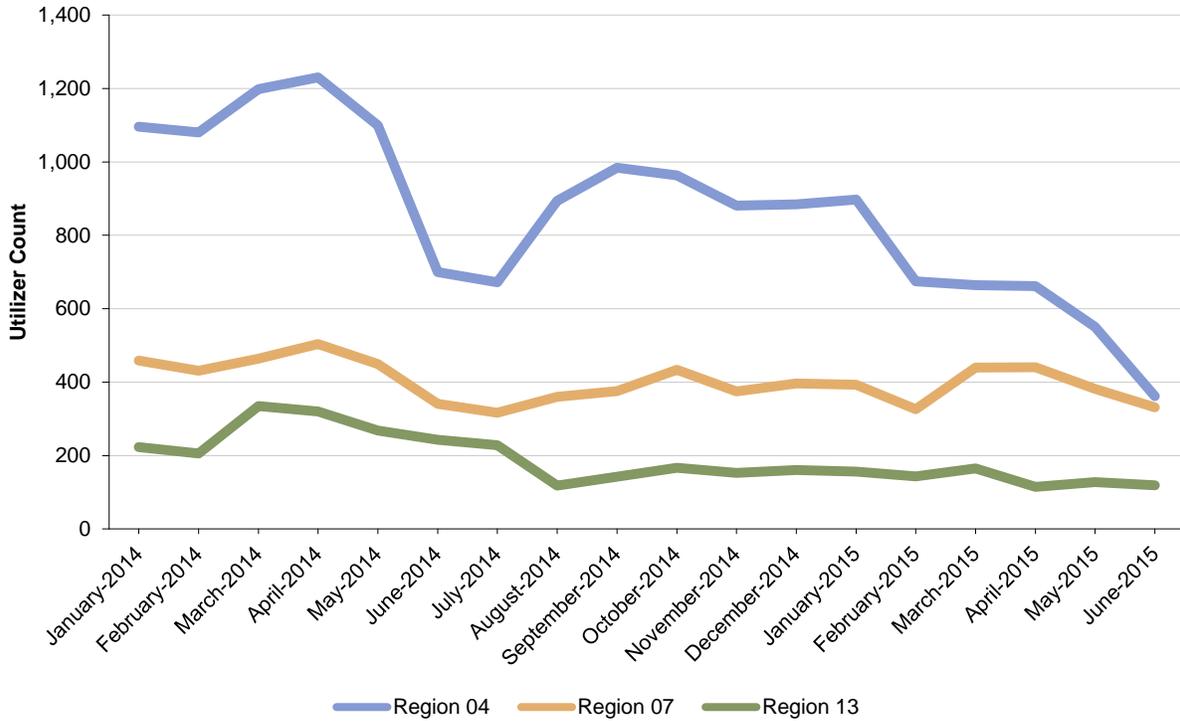


Figure 104 - Behavioral Health Services (FFS) utilizer count, HSRs 04, 07, 13

The utilizer count showed higher numbers in Region 04. This appears to align with CHAS data, which estimates the population of insured persons in Region 04 to be approximately four times that of Region 07 and approximately nine times that of Region 07. Although the utilizer count declined over time, we believe this reflects the particular needs of this small population, which may increase or decrease sporadically, and is not an indicator of an access issue.

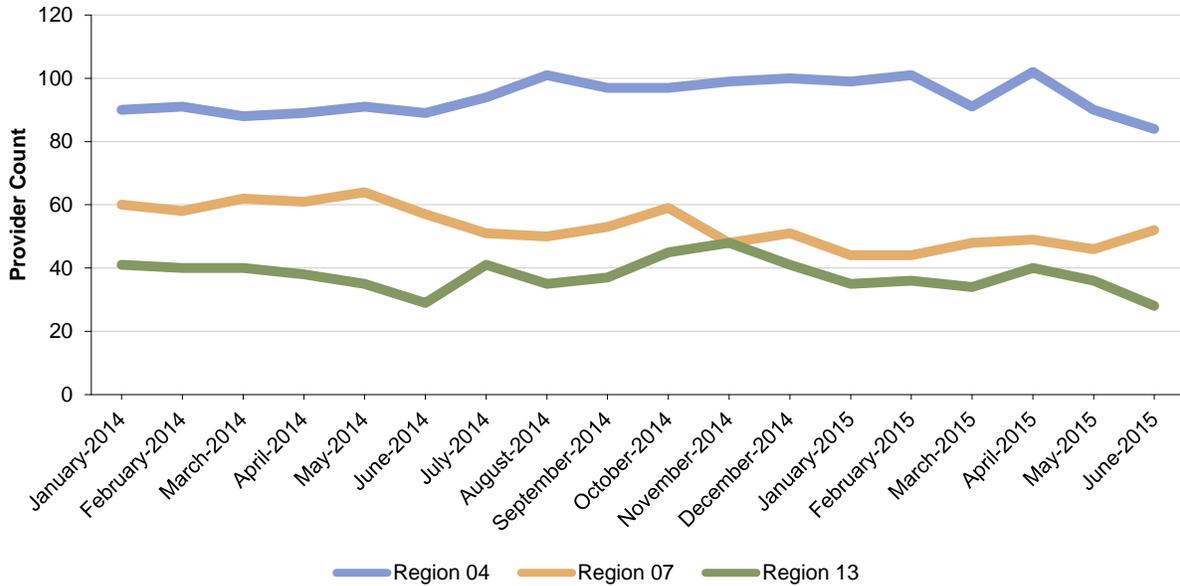


Figure 105 - Behavioral Health Services (FFS) provider count, HSRs 04, 07, 13

The provider count appears relatively stable year-over-year, with higher numbers in Region 04. This is logical when looking at utilizer count for the regions.

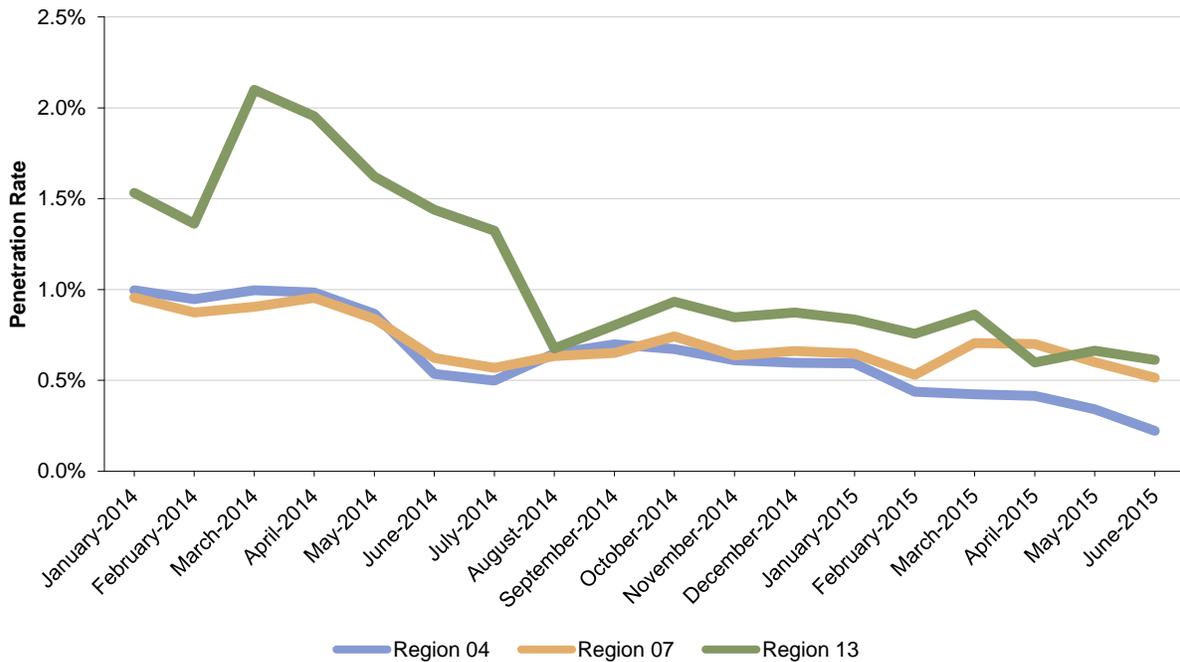


Figure 106 - Behavioral Health Services (FFS) penetration rate, HSRs 04, 07, 13

HSR 04 showed a sharp downward utilizer count trend, coupled with a steadily decreasing service penetration rate (falling from 1.0% to 0.25%). It could be that utilization was shifted to the BHO for the region and that FFS utilization was simply no longer necessary. This argument is strengthened by the

steady number of active billing providers, which suggests that the change was not the result from providers leaving the region. HSR 04 will be monitored closely in the coming years.

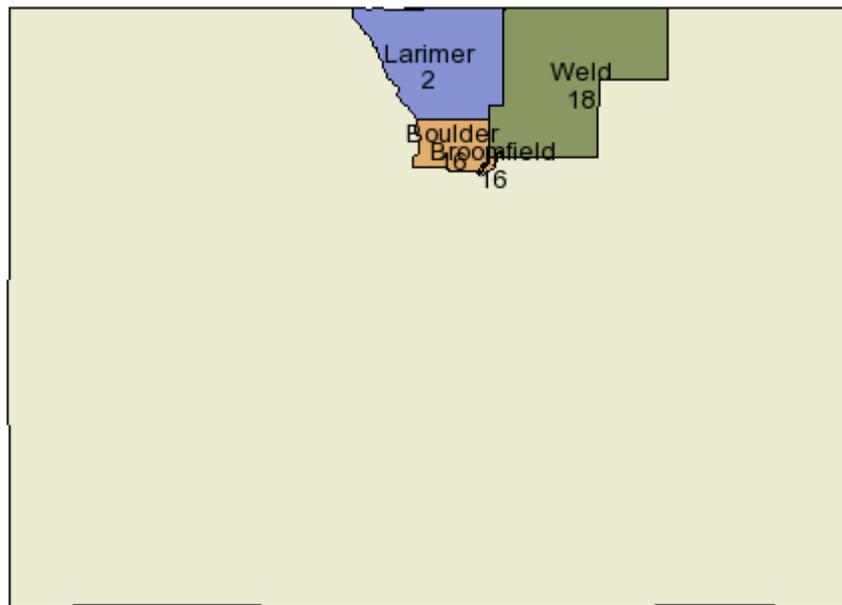
Analysis for HSRs 04, 07, and 13

Active provider counts were stable for all three HSRs. While the penetration rate in HSR 04 trended downward slightly, and will be monitored, these statistics do not indicate an access issue.

HSRs 02, 16, and 18

Health Statistic Regions 02, 16, and 18 are comprised of residents in the central and northern part of the State. These three regions reported approximately 770,000 insured persons in 2013, and grew to approximately 825,000 insured persons by 2015.

Predominately rural and somewhat mountainous, with numerous urban centers, these HSRs account for approximately 15.1% of the State's overall population.



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Figure 107 - Diagram of HSRs 02, 16, 18

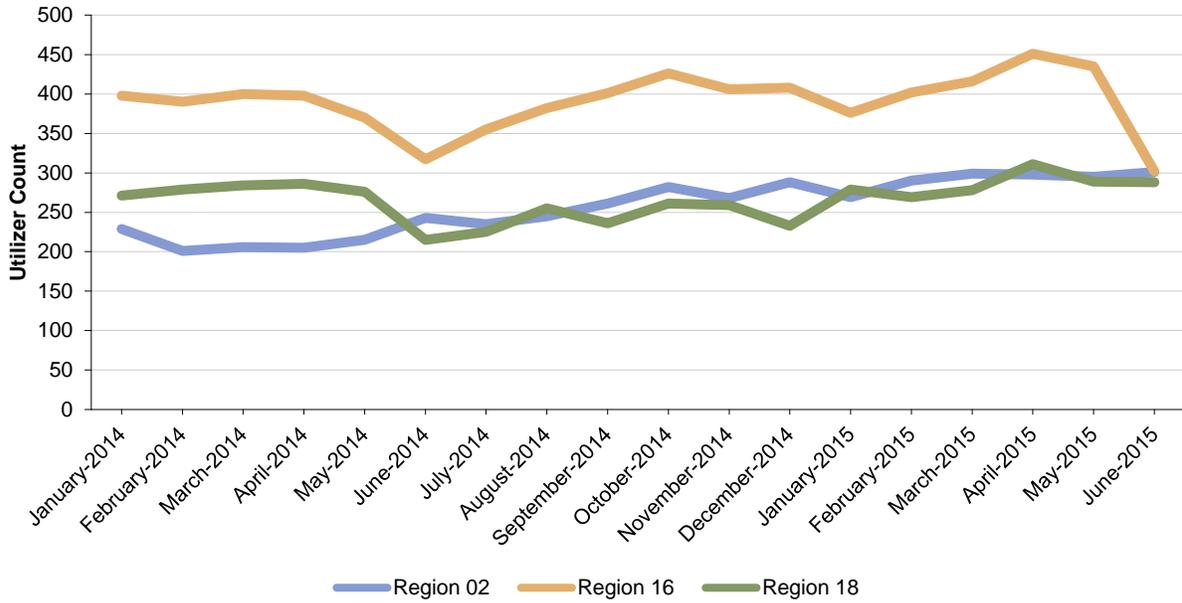


Figure 108 - Behavioral Health Services (FFS) utilizer count, HSRs 02, 16, 18

The utilizer counts appear to remain relatively stable year-over-year for Regions 02 and 18. Region 16 saw a sharp drop, beginning April 2015. This pattern was also seen in April 2014, which was followed by a rebound. It could be this is part of a cyclical trend for the region. It will be monitored to ensure there is not an access deficiency.

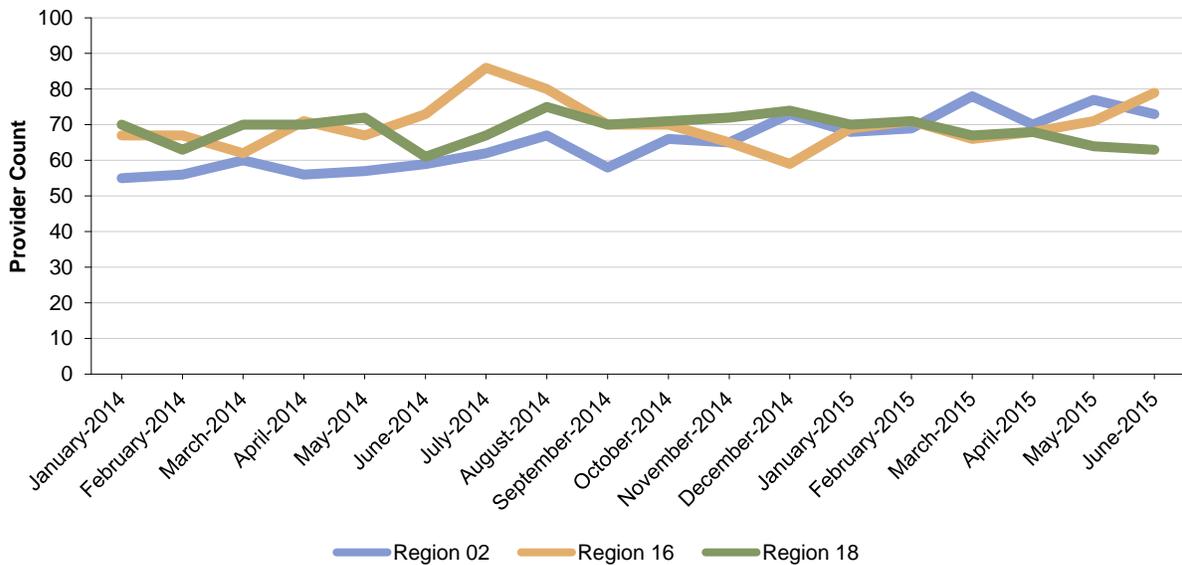


Figure 109 - Behavioral Health Services (FFS) provider count, HSRs 02, 16, 18

The provider counts for these regions appear to mimic that of members, with stable trends and no concerning increases or decreases from 2014 to 2015.

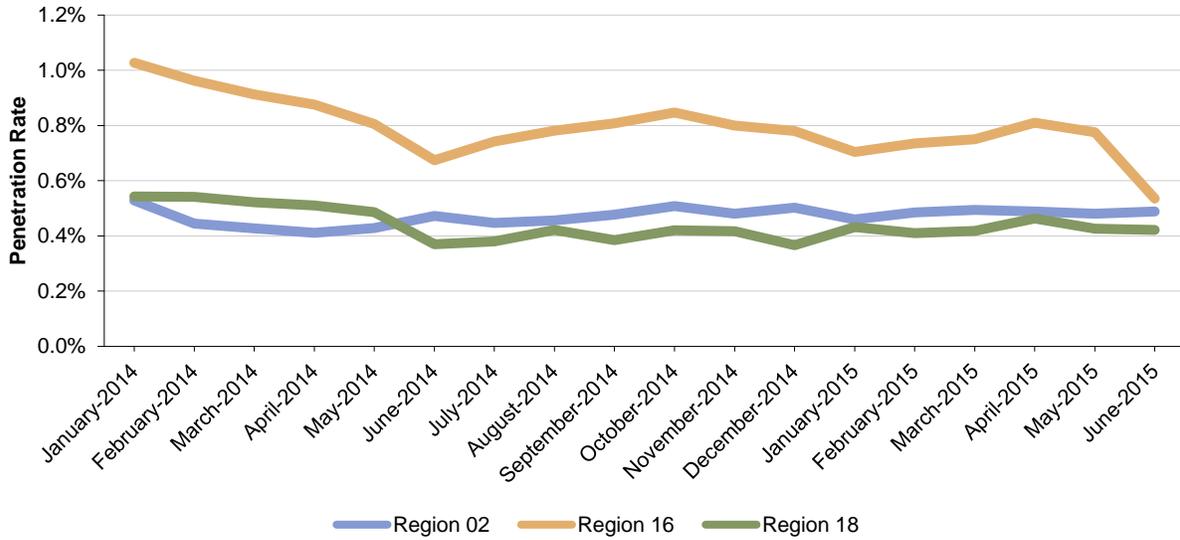


Figure 110 - Behavioral Health Services (FFS) penetration rate, HSRs 02, 16, 18

While HSR 16 showed a sharp decrease in utilizer count from April to June 2015, the active provider count increased by 10%. This combination does not contradict the penetration rate trend, which sharply decreased in the same time period. This trend may be cyclical in nature and will be monitored to ensure there is not an access issue.

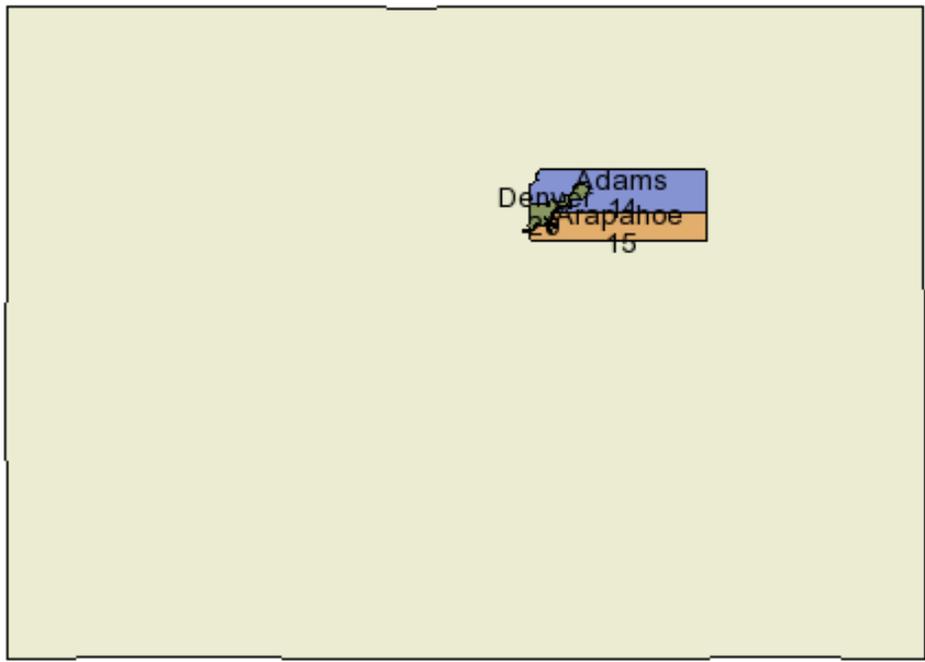
Analysis for HSRs 2, 16, and 18

This trend for Region 16 will be monitored in the coming quarters to determine if an access issue is present. Trends in Regions 02 and 18 were stable. These statistics do not indicate an access issue.

HSRs 14, 15, and 20

Health Statistic Regions 14, 15, and 20 are comprised of residents in the central part of the State. These three regions reported approximately 1,333,000 insured persons in 2013, and grew to approximately 1,377,000 insured persons by 2015.

Predominately urban, geographically, these HSRs account for approximately 25.2% of the State's overall population.



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Figure 111 - Diagram of HSRs 14, 15, 20

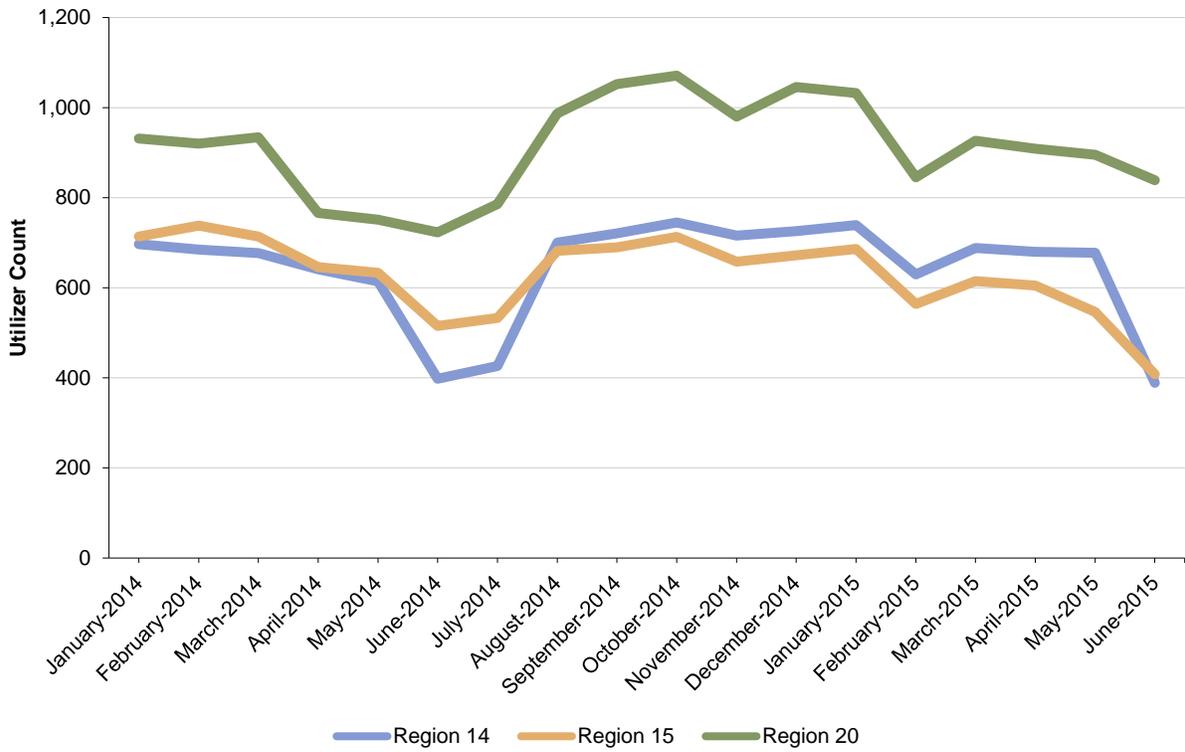


Figure 112 - Behavioral Health Services (FFS) utilizer count, HSRs 14, 15, 20

The utilizer count for Region 20 was larger than that of Regions 14 and 15. However, this number is not concerning and appears to align with CHAS data, which reports Region 20 as having 23% more Medicaid members than Region 15, and approximately 32% more Medicaid members than Region 14. Provider count appears to remain stable year-over-year.

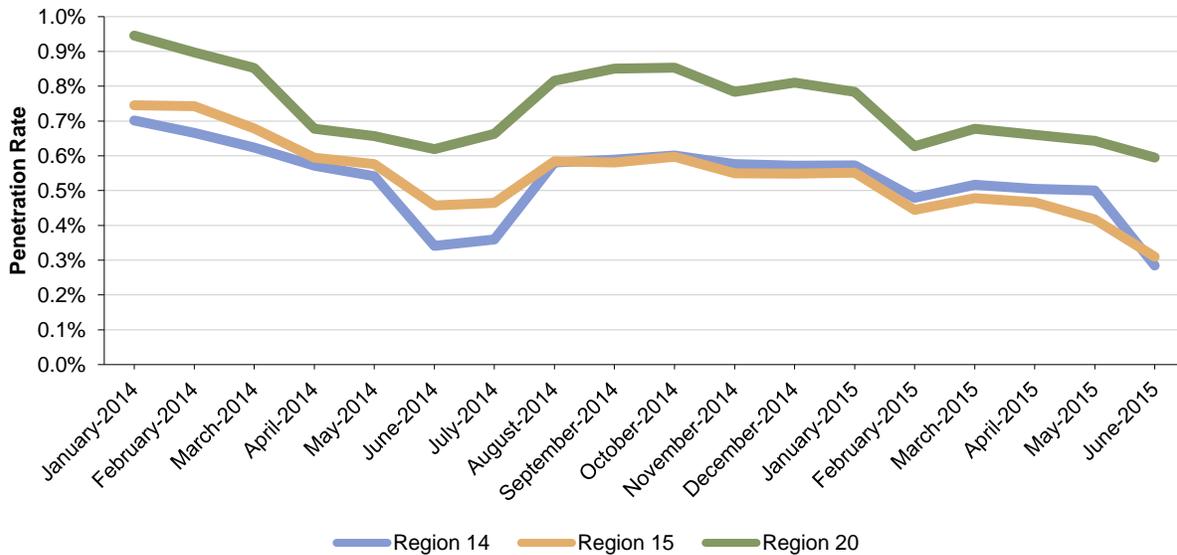


Figure 113 - Behavioral Health Services (FFS) penetration rate, HSRs 14, 15, 20

HSRs 14 and 15 showed falling utilizer counts from May through June 2015. Penetration rates simultaneously fell, which is to be expected if the utilizer count decreased.

Analysis for HSRs 14, 15, and 20

While penetration rates appear to have fallen beginning in 2015, active provider counts remained stable through this time period and the deviation is not outside of 18-month historical fluctuation.

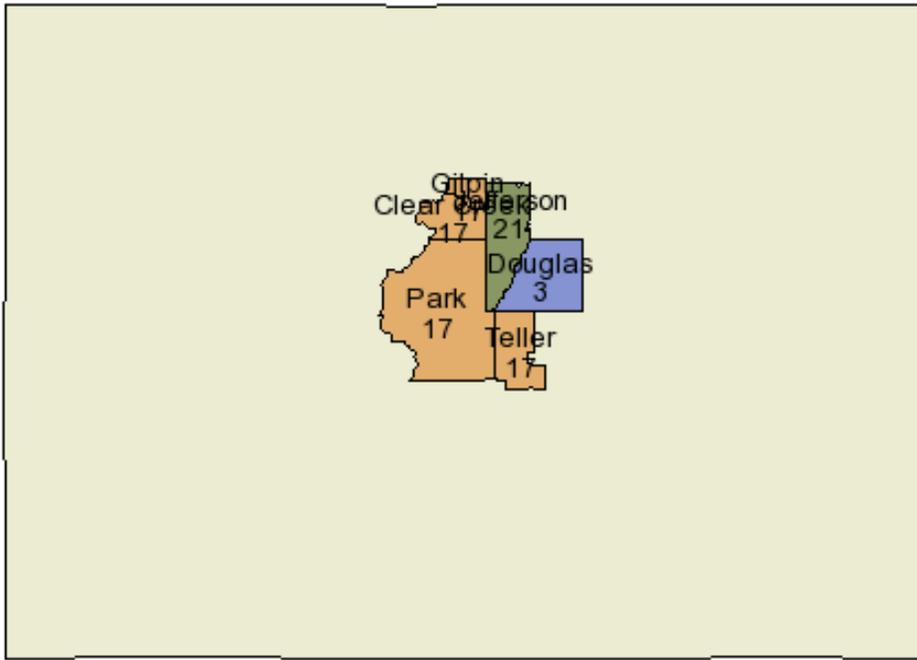
Provider count was omitted due to HIPAA privacy requirements.

These statistics do not indicate an access issue.

HSRs 03, 17, and 21

Health Statistic Regions 03, 17, and 21 are comprised of residents in the central part of the State. These three regions reported approximately 79,000 insured persons in 2013, and grew to approximately 876,000 insured persons by 2015.

A mix of urban and rural geography, these HSRs account for approximately 16% of the State's overall population.



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Figure 114 - Diagram of HSRs 03, 17, 21

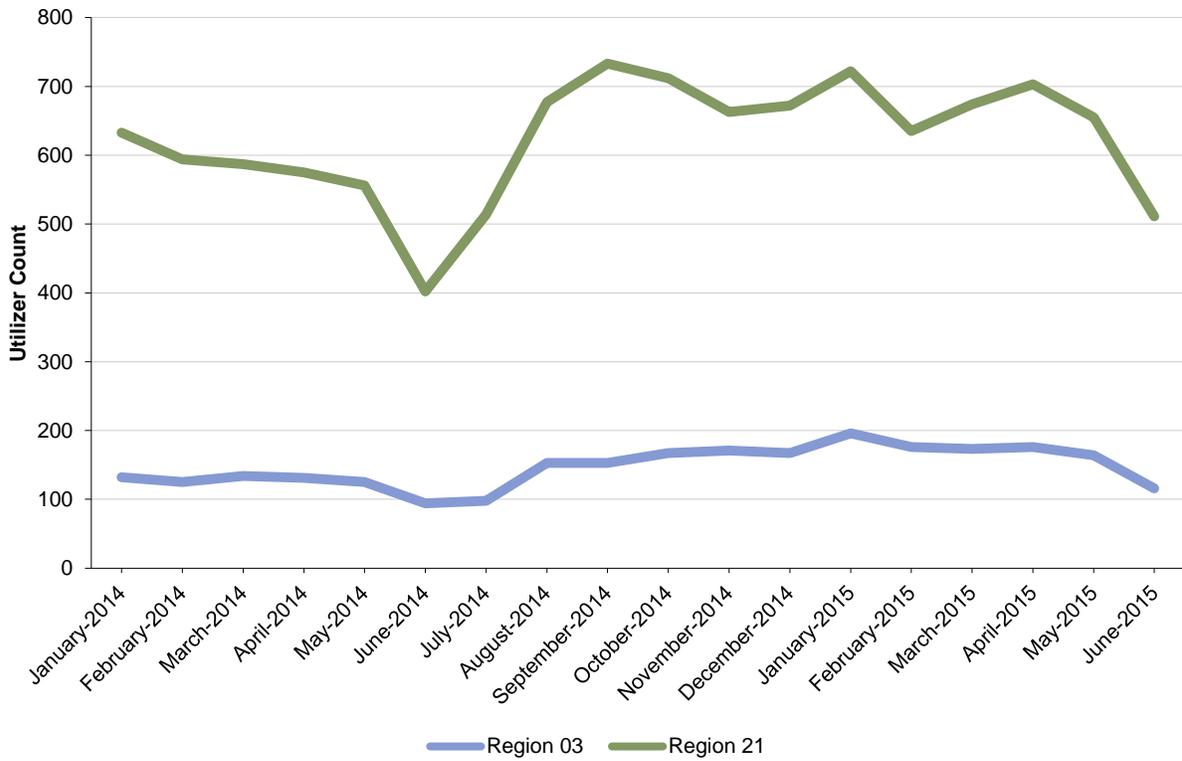


Figure 115 - Behavioral Health Services (FFS) utilizer count, HSRs 03, 21

The utilizer count appears much higher in Region 21 than Region 03. This aligns with CHAS data, which showed Region 21 as having approximately two times the number of Medicaid members than that of Region 03. Member count for HSR 17 has been blinded per HIPAA requirements.

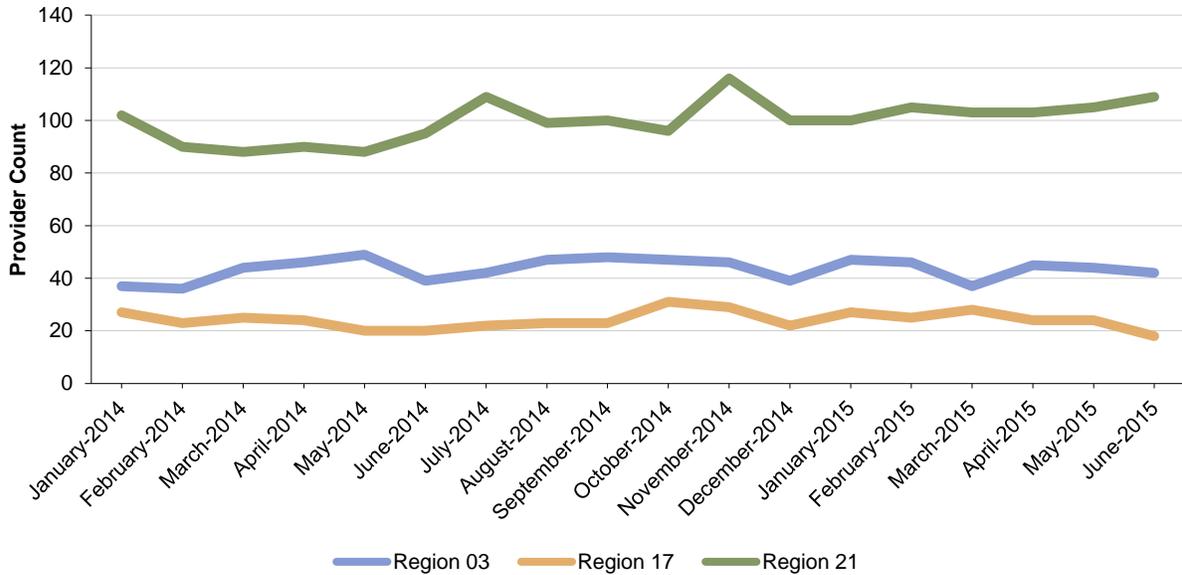


Figure 116 - Behavioral Health Services (FFS) provider count, HSRs 03, 17, 21

Similar to utilizer count, the number of providers was much higher in Region 21, compared to Regions 03 and 17. However, in general, provider counts appear relatively stable year-over-year.

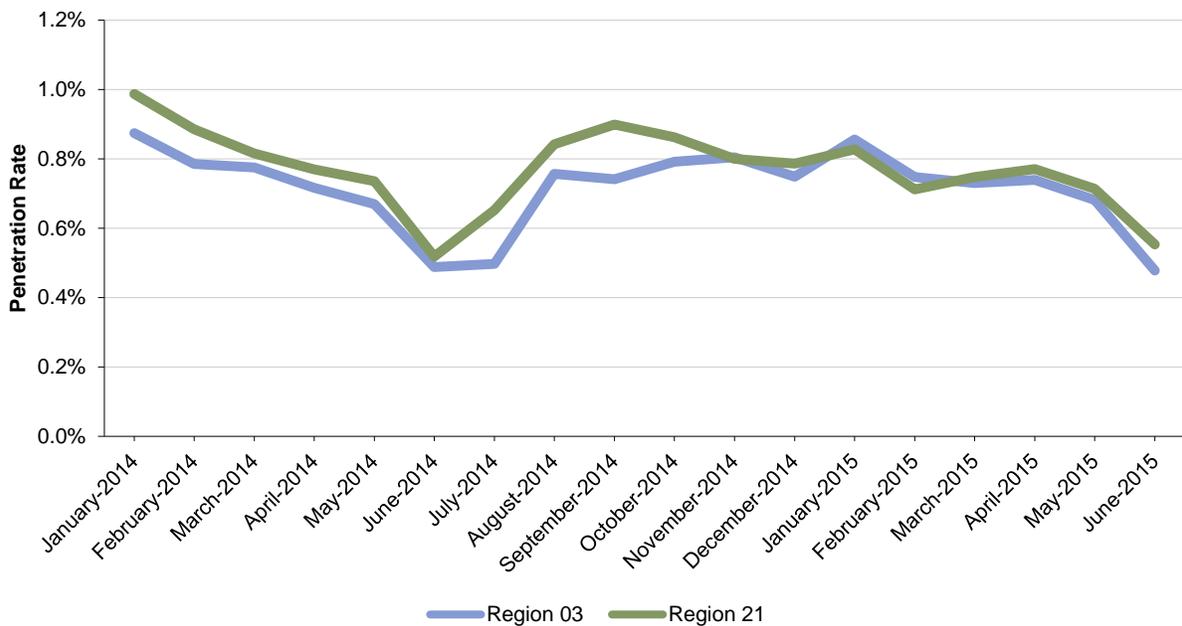


Figure 117 - Behavioral Health Services (FFS) penetration rate, HSRs 03, 21

Penetration rates for these regions appear to fluctuate year-over-year, with a slight decrease beginning in February 2015. Member count for HSR 17 has been blinded per HIPAA requirements.

Analysis for HSRs 03, 17, and 21

While penetration rates fell for HSRs 03 and 21 from May to June 2015, this deviation is not outside of normal fluctuation and, when taken into consideration with the stable active provider count in the same time period, does not indicate an access issue.

Behavioral Health Services (FFS) Analysis by Provider Type and Place of Service
 Figures 118 and 119 are FY2015 snapshots of Billing Provider type by utilizer count. They depict the distribution of billing provider types within the service category who deliver the benefit. *Fulfills requirement 42 CFR 447.203(b)(1)(ii)*

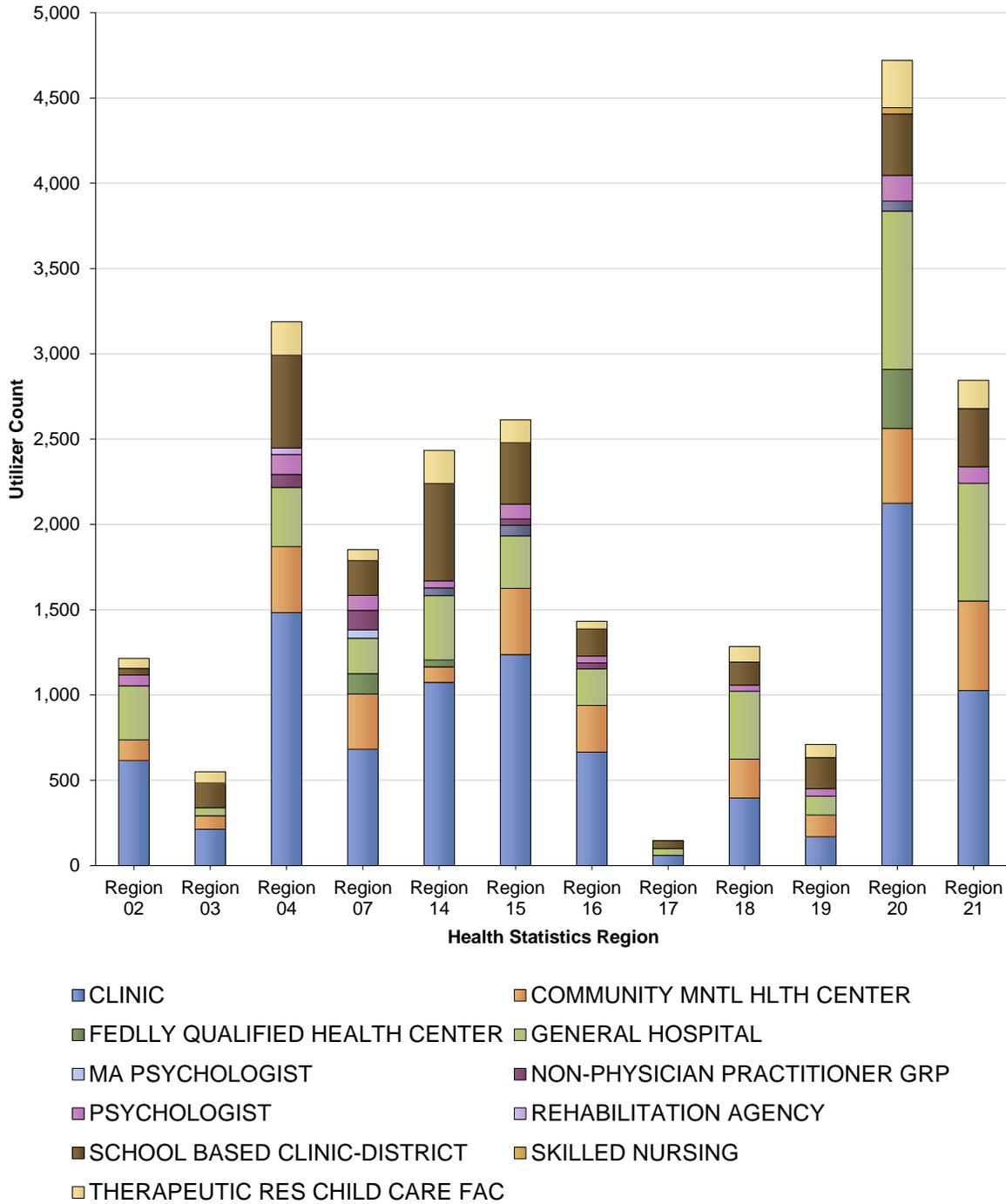


Figure 118 - Behavioral Health Services (FFS) provider type by urban HSRs

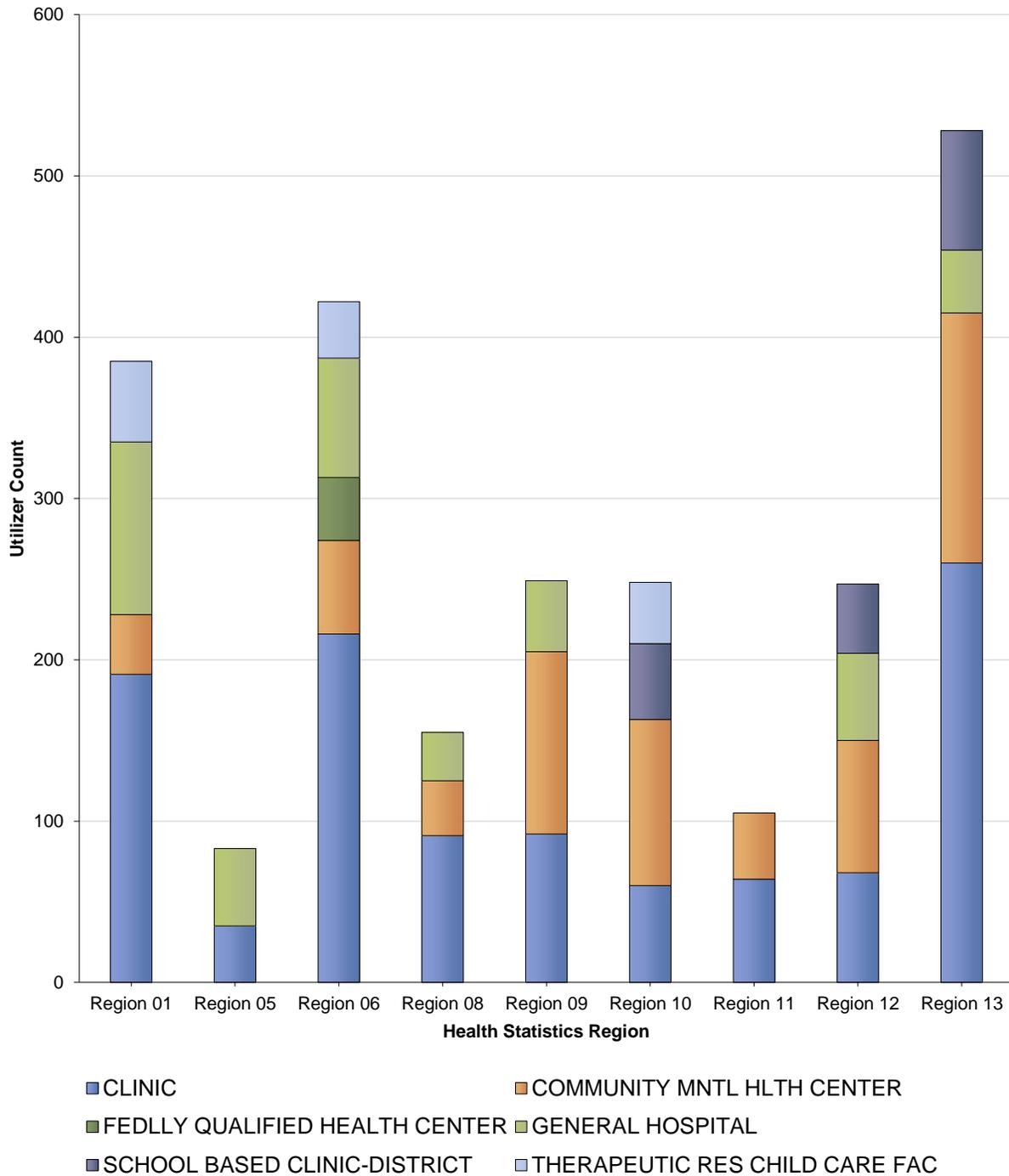


Figure 119 – Behavioral Health Services (FFS) provider type by rural HSRs

Analysis of Provider Type

The benefit is delivered by a variety of provider types consistently across HSRs. Only a few HSRs (7, 14, and 20) are additionally served Behavioral Health Services FFS by federally qualified health centers (FQHCs). Their utilization contribution makes up a relatively small portion of the total provider

contributions. Community mental health center (CMHC) likewise contributes less than a majority of provider types.

Figures 120 and 121 are FY 2014-15 snapshots of Place of Service by utilizer count. They depict the distribution of place of service (the setting where the benefit was delivered) within the service category. Note: Below, “skilled nursing” refers to Place of Service (POS) code 20, "skilled nursing facility" POS 31, and “nursing facility” POS 32. *Fulfills requirement 42 CFR 447.203(b)(1)(ii)*

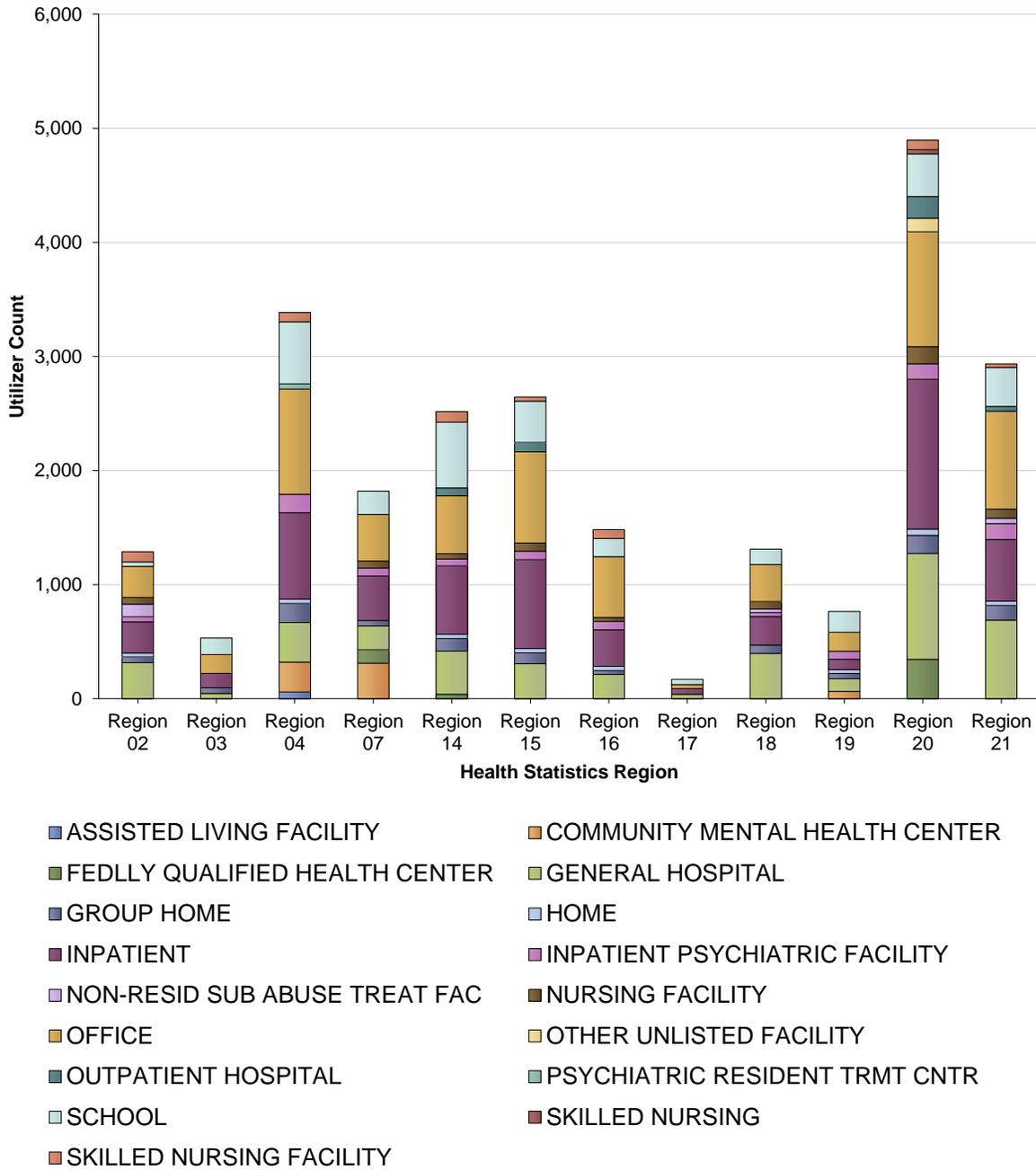


Figure 120 - Behavioral Health Services (FFS) place of service by urban HSRs

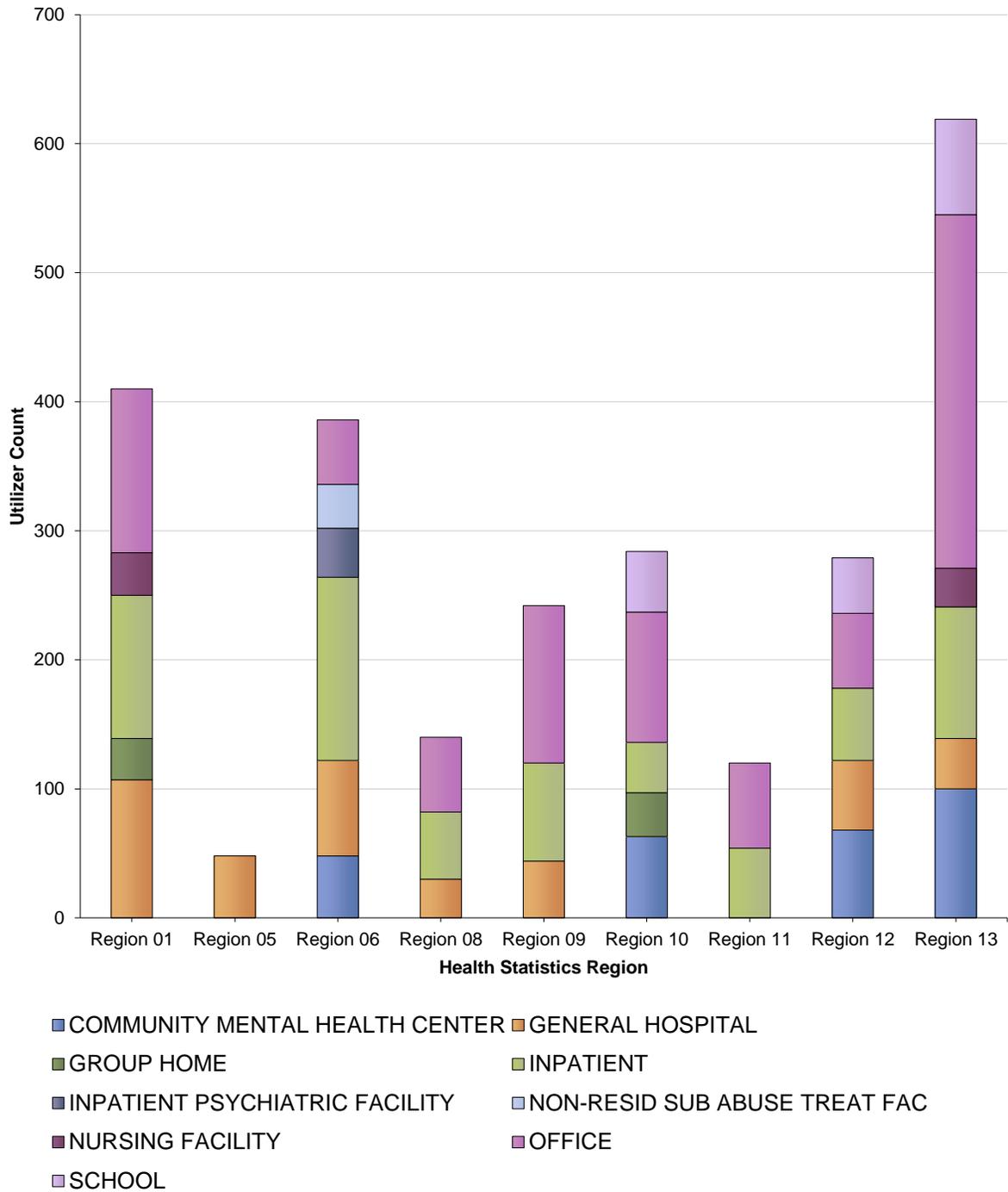


Figure 121 - Behavioral Health Services (FFS) place of service by rural HSRs

Analysis of Place of Service

The benefit was delivered consistently, in a variety of service locations across HSRs. Utilization patterns were within the expected range. ‘Office’ place consistently had the highest utilization figures. HSR 5 only had one place of service, ‘general hospital’; this is because utilization there is extremely low, likely because there is little need for the fee-for-service version of the benefit.

Behavioral Health Services (FFS) Colorado Health Access Survey Data

No 2015 CHAS data pertinent to this service was available

Behavioral Health Services (FFS) Rate Comparison

Actual or Estimated Levels of Provider Payment

Fulfills requirement 42 CFR 447.203(b)(1)(v)

In aggregate, the 2016 Health First Colorado rates for Behavioral Health Services (FFS) varied by place of service based on the top 50 procedure codes used to bill for services. Of the top 50 codes, the Department identified at least 10 Medicaid and private payer codes in the CIHVC data (from the Colorado All Payer Claims Database) that matched and could be used comparative analysis. Available Medicare codes did not differentiate by place of service, therefore the average of all top codes for all places of service was used for comparative analysis.

This table displays the percentage Medicaid rates differ from private payers (CIVHC difference) and Medicare. For example, Medicaid rates are 5.61% below Medicare. The wide difference in CIVHC rate percentages below reflects the different codes that were both available and were most commonly used. Each place of service had different commonly used codes available.

Place of Service	CIVHC % Difference	Medicare % Difference
Office	-27.31%	-5.61%
Home	223.42%	-5.61%
Assisted living facility	370.51%	-5.61%
Urgent care facility	-35.57%	-5.61%
Inpatient hospital	4.90%	-5.61%
Outpatient hospital	-99.37%	-5.61%
Emergency room -- hospital	-22.49%	-5.61%
Skilled nursing facility	-69.88%	-5.61%
Nursing facility	274.55%	-5.61%
Inpatient psychiatric facility	33.40%	-5.61%
Community mental health center	-0.01%	-5.61%
Comprehensive inpatient rehabilitation facility	72.94%	-5.61%
Rural health clinic	-34.01%	-5.61%
Other place of service	-71.93%	-5.61%
AVERAGE	44.23%	-5.61%

Table 9 - Behavioral Health Services (FFS) rate comparison table

Behavioral Health Services (FFS) Input from Beneficiaries, Providers, and Stakeholders

Fulfills requirement 42 CFR 447.204(a)(2)

Fulfills requirement 42 CFR 447.204(b)(3) – as applicable under ‘Specific Analysis of Input from Stakeholders Affected by a Payment Restructure or Reduction’

Behavioral Health Services (FFS) Direct-to-Staff Input

Department staff occasionally receive unsolicited input directly from beneficiaries, providers, and stakeholders concerning access to care for this service while performing their operational duties. Staff address and catalogue those access comments in accordance with the procedures detailed in the Access Monitoring Review Plan – Appendix A.

The Department has received no direct-to-staff comments concerning access to care for this service.

Behavioral Health Services (FFS) Targeted Stakeholder Input and Input from General Public Notice

A draft of this Plan was sent to key stakeholders and was made publically available on the Department’s website for 30 day public comment. Feedback and input was accepted through email and through an online survey and is summarized in Appendix K. Several stakeholders pointed to anomalies in the way the data and analysis above was originally presented. Where applicable, the Department has clarified.

Several stakeholders asserted that the analysis above excludes sufficient analysis of access to mental health. Specifically: existing CHAS data on mental health visits; and mention of lack of treatment for autism, other developmental disabilities and brain injuries. Available CHAS data was not suitable for comparison to the fee-for-service (non-BHO) population. Pursuant to federal regulation 42 CFR 447.203, the Department did not assess access to specific diagnoses within the categories of benefits that must be analyzed, such as autism, development disabilities or brain injuries.

Behavioral Health Services (FFS) Access Issues Discovered As a Result of This Review

Fulfills requirements 42 CFR 447.203(b)(4)

This is a list of the Access Issues identified using the data available in this review. Data which suggests an Access Issue will be investigated and monitored for a period of two consecutive quarters to ensure the pattern is not an artifact or data anomaly. If investigation does reveal a deficit, the Access Issue becomes an Access Deficiency which triggers the process described in the Access Monitoring Review Plan – Appendix B (42 CFR 447.203(b)(8)).

No access issues were identified as a result of this review, however certain trends warrant further investigation. Staff have become aware of certain regions that should be closely monitored. Region 04’s utilizer count and penetration rate decreased between January 2014 and June 2015. While there is evidence to suggest that this drop represented a shift to the BHO system, HSR 04 will be monitored closely. HSR 16’s utilizer count dropped from April to June 2015, while the active provider count increased by 10%. While this trend may be cyclical in nature, it too will be monitored to ensure there is not an access issue. These regions will be investigated further and reported on in the next version of the Plan.

Behavioral Health Services (FFS) Extent to Which Beneficiary Needs Are Fully Met *Fulfills requirements 42 CFR 447.203(b)(1)(i)*

The nature of this benefit is for it to be utilized in a wide variety of ways across the State by a small population of Medicaid members who are either exempt from BHO enrollment, are receiving services for conditions not covered by the BHO contracts, or are receiving services not covered by the BHO contracts, such as long-acting anti-psychotic medications. Analysis of data in this Plan did not indicate an access issue, and the Department did not receive comments regarding access issues specific to fee-for-service Behavioral Health Services. Access will continue to be monitored in accordance with the Access Monitoring Review Plan.

The Department's analytical conclusion is that Behavioral Health Services (FFS) are sufficient to enlist enough providers so that services are available at least to the extent they are available to the general population in each geographic area, pursuant to section 1902(a)(30)(A) of the Social Security Act.

Appendix I: Access Monitoring Analysis - Obstetric Services

Fulfills requirement 42 CFR 447.203(b)(5)(ii)(D)

Obstetric Services Definition of Service

Health First Colorado provides fee-for-service maternity services with risk-appropriate care that will enhance optimal maternal and child health outcomes. Services include early and continuous risk screening for pregnant women, early entry into prenatal care, prenatal care delivered by the provider/specialty level best suited to the risk of the member, labor and delivery services appropriate to member risk, and postnatal care as needed.

Obstetric Services Characteristics of the Beneficiary Population

Fulfills requirements 42 CFR 447.203(b)(1)(iv)

Available services and payments do not vary for member populations or geographic locations throughout the State. There are no variations in available maternity services and payment between pediatric and adult members or members with disabilities, for medically necessary service. However, several additional non-maternity related services may be provided to members who are children (through EPSDT) and to individuals with disabilities (through waiver programs).

Obstetric Services Administrative Claims Utilization Data

Figure 122 is a FY 2014-15 snapshot of demographic groups (children/adults/individuals with disabilities) by utilizer count. This depicts the demographic group distribution of service utilizers, which informs the Beneficiary Characteristic description. *Fulfills requirement 42 CFR 447.203(b)(1)(iv)*

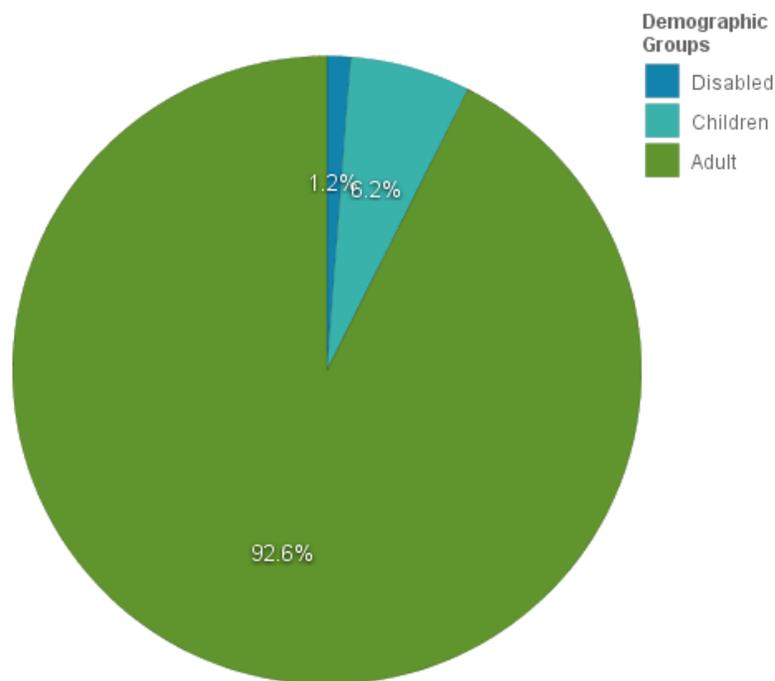


Figure 122 – Obstetric Services utilizers, by demographic groups

Analysis of Demographic Groups

Adults made up 92.6% of the utilizers of this service, but services were available for all members—including persons with disabilities and youth. This statistic is consistent with expectations and, as such, does not indicate an access issue, but can only be interpreted in context with other statistics.

FY 2014-15 Snapshot of gender groups by utilizer count. *Fulfills requirement 42 CFR 447.203(b)(1)(iv)*

100% of utilizers are female. No graph is produced to represent this.

Figure 123 is a FY 2014-15 snapshot of age groups by utilizer count. This depicts the age distribution of service utilizers. *Fulfills requirement 42 CFR 447.203(b)(1)(iv)*

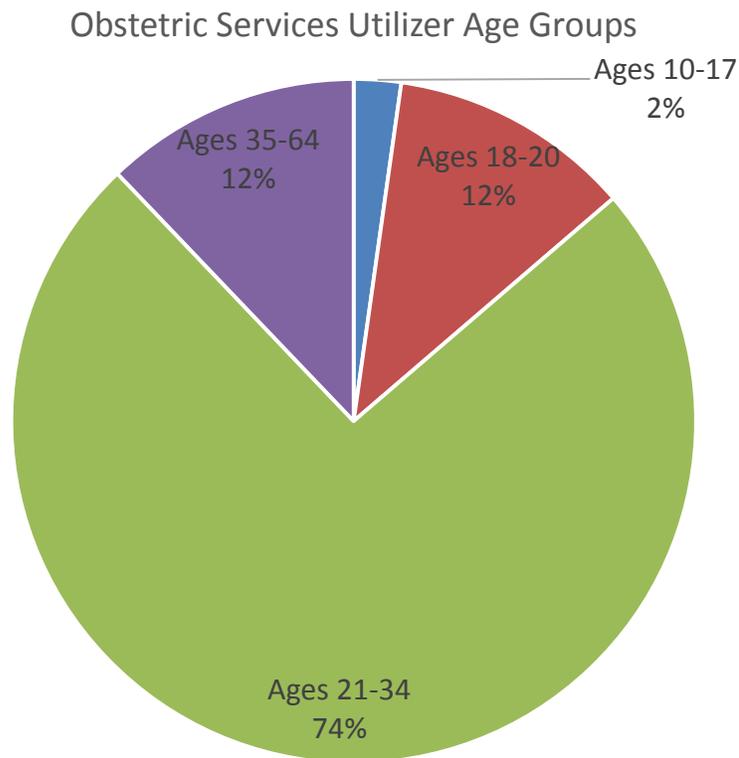


Figure 123 - Obstetric Services utilizers by age groups

Analysis of Age Groups

Most utilizers (74.1%) were between the ages of 21-34, which is consistent with expectations for this service category. This does not indicate an access issue, but can only be interpreted in context with other statistics.

Table 10 is a FY 2014-15 snapshot of top 10 diagnoses by utilizer count, further broken out by demographic group. It includes what percentage of total service utilizers each demographic group constituted. This characterizes the needs of the beneficiary population. *Fulfills requirement 42 CFR 447.203(b)(1)(iv)*

Top 10 Root Diagnosis Codes		
Rank: 1 Principal Diagnosis V22		
Code Description NORMAL PREGNANCY		
Total Members: 24,972		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	22,702	90.9%
Children	1,958	7.8%
Individuals with Disabilities	312	1.2%
Rank: 2 Principal Diagnosis 650		
Code Description NORMAL DELIVERY		
Total Members: 8,714		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	8,106	93.0%
Children	532	6.1%
Individuals with Disabilities	76	0.9%
Rank: 3 Principal Diagnosis 664		
Code Description TRAUMA TO PERINEUM AND VULVA DURING DELIVERY		
Total Members: 5,475		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	4,979	90.9%
Children	463	8.5%
Individuals with Disabilities	33	0.6%
Rank: 4 Principal Diagnosis 654		
Code Description ABNORMALITY OF ORGANS & SOFT TISSUES OF THE CERVIX		
Total Members: 5,212		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	5,041	96.7%
Children	96	1.8%
Individuals with Disabilities	75	1.4%
Rank: 5 Principal Diagnosis 648		
Code Description OTHER CURRENT CONDITIONS IN THE MOTHER CLASSIFIED ELSEWHERE		
Total Members: 4,031		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	3,810	94.5%

Children	155	3.8%
Individuals with Disabilities	66	1.6%
Rank: 6 Principal Diagnosis 659		
Code Description OTHER INDICATIONS FOR CARE OR INTERVENTIONS RELATED TO LABOR AND DELIVERY		
Total Members: 3,096		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	2,902	93.7%
Children	161	5.2%
Individuals with Disabilities	33	1.1%
Rank: 7 Principal Diagnosis 645		
Code Description LATE PREGNANCY (POST-TERM)		
Total Members: 2,910		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	2,725	93.6%
Children	Blinded	
Individuals with Disabilities	Blinded	
Rank: 8 Principal Diagnosis 658		
Code Description OTHER PROBLEMS ASSOCIATED WITH AMNIOTIC CAVITY AND MEMBRANE		
Total Members: 2,113		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	1,958	92.7%
Children	Blinded	
Individuals with Disabilities	Blinded	
Rank: 9 Principal Diagnosis 656		
Code Description OTHER FETAL & PLACENTAL PROBLEMS AFFECTING MANAGEMENT OF MOTHER		
Total Members: 1,992		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	1,845	92.6%
Children	Blinded	
Individuals with Disabilities	Blinded	
Rank: 10 Principal Diagnosis 642		
Code Description HYPERTENSION COMPLICATING PREGNANCY, CHILDBIRTH AND PUERPERIUM		
Total Members: 1,876		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	1,751	93.3%
Children	Blinded	
Individuals with Disabilities	Blinded	

Table 10 - Obstetric Services top 10 diagnosis by utilizer count

Analysis for Top 10 Diagnoses

The top diagnoses are as expected. Blank items in the table above were blinded comply with HIPAA requirements. The diagnoses above indicate that all medically necessary services were readily available to Medicaid members; the majority of diagnoses were related to “normal” pregnancy and delivery. As the top diagnoses are consistent with expectations, these statistics do not indicate an access issue, but cannot be interpreted in isolation.

Obstetric Services Utilization Analysis by Geographic Region

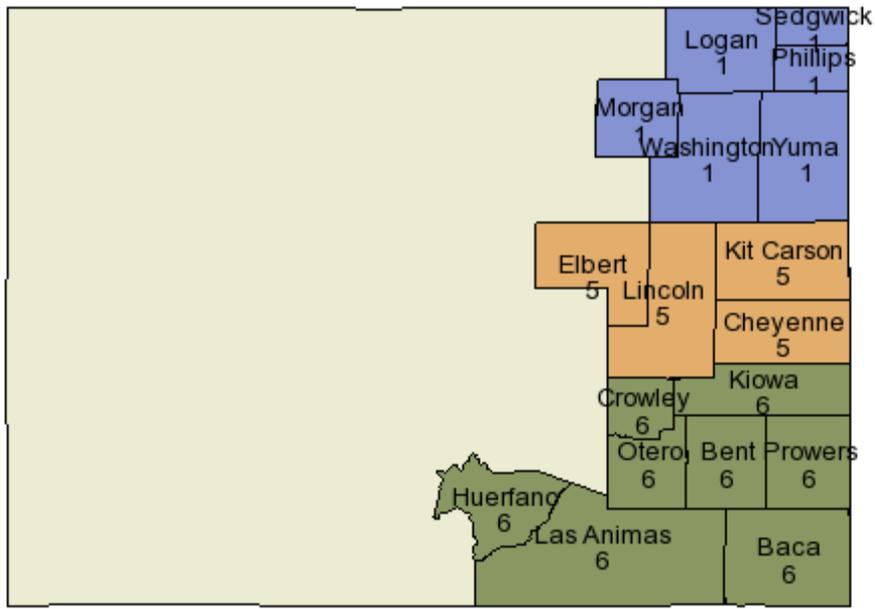
To best review access to health care services for Health First Colorado members, through the lense of administrative claims utilization data, the Department plotted three sets of data points stratified by each HSR. These were the total volume utilizer count, the active billing provider count, and the service penetration rate.³² What follows is a graphical examination of 18 month trends for each of seven groupings of HSRs. Only the utilization of members for whom Health First Colorado was the payer are shown.

HSRs 01, 05, and 06

Health Statistic Regions 01, 05, and 06 are comprised of residents from the eastern part of the State. These three regions reported approximately 152,000 insured persons in 2013, and grew to approximately 172,000 insured persons by 2015.

Predominately rural, these HSRs account for approximately 3.1% of the State's overall population.

³² If Medicaid members utilized other services that were paid for by their private insurance or Medicare, that utilization is not captured here.



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Figure 124 – Diagram of HSRs 01, 05, 06

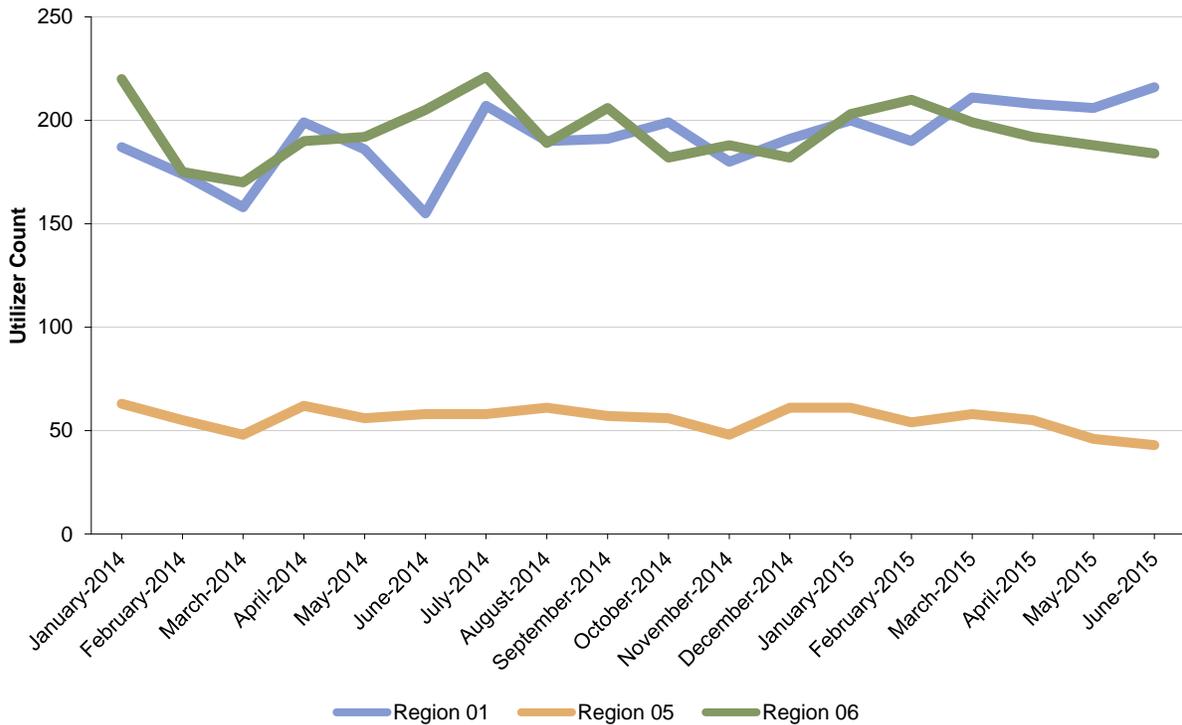


Figure 125 - Obstetric Services utilizer count, HSRs 01, 05, 06

The utilizer counts for Regions 01 and 06 were higher than that of Region 05. This appears to align with CHAS data, which reports a larger number of Medicaid members in Regions 01 and 06 than in Region 05.

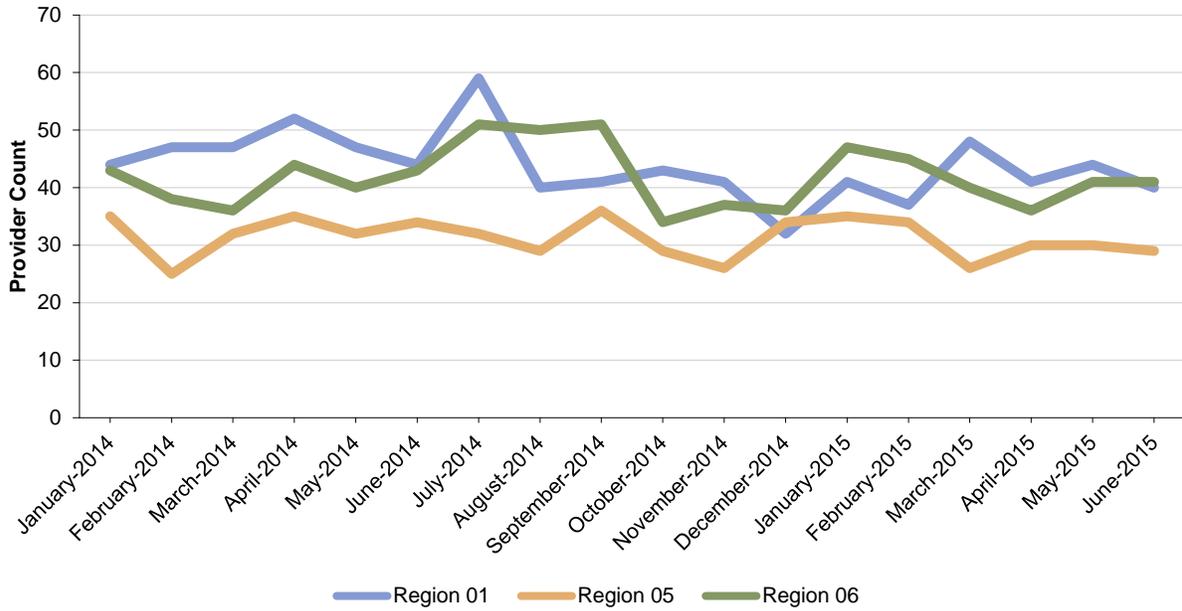


Figure 126 - Obstetric Services provider count, HSRs 01, 05, 06

The provider counts for all regions appear relatively similar and remained stable year-over-year. While Region 05 appears to have had fewer providers, this is logical when compared to utilizer count, and appears to be robust despite reporting fewer members to serve.

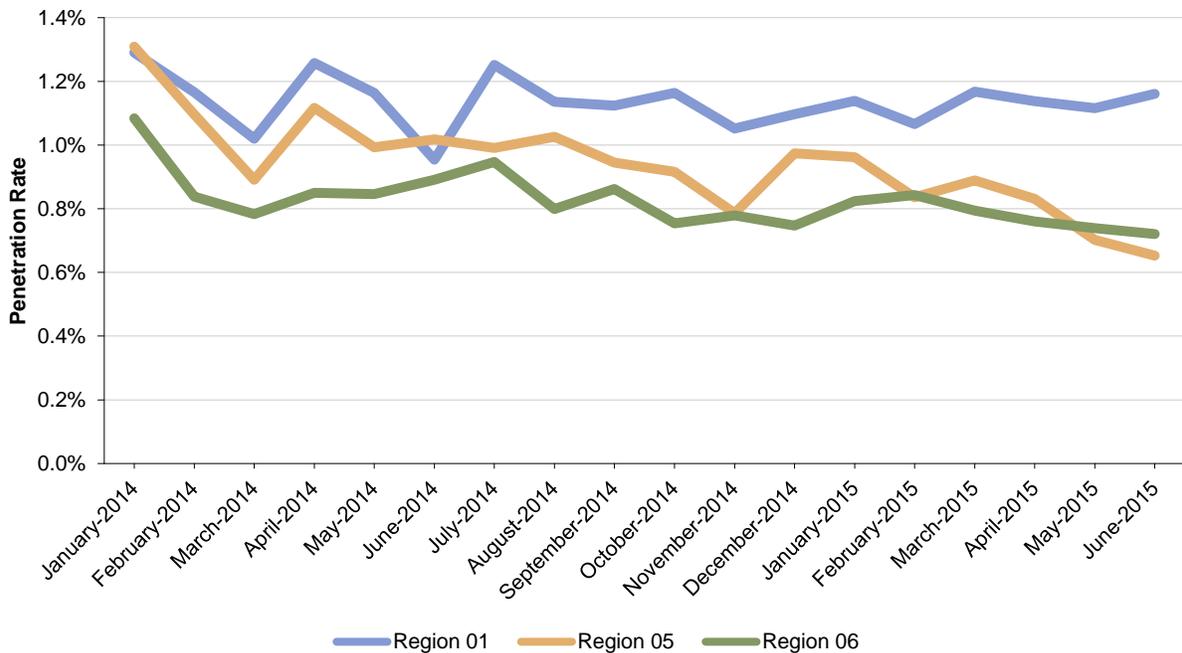


Figure 127 - Obstetric Services penetration rate, HSRs 01, 05, 06

The penetration rates for these regions appear relatively stable year-over-year, with slight decreases beginning in February 2015 in Regions 05 and 06.

Analysis for HSR 01, 05, and 06

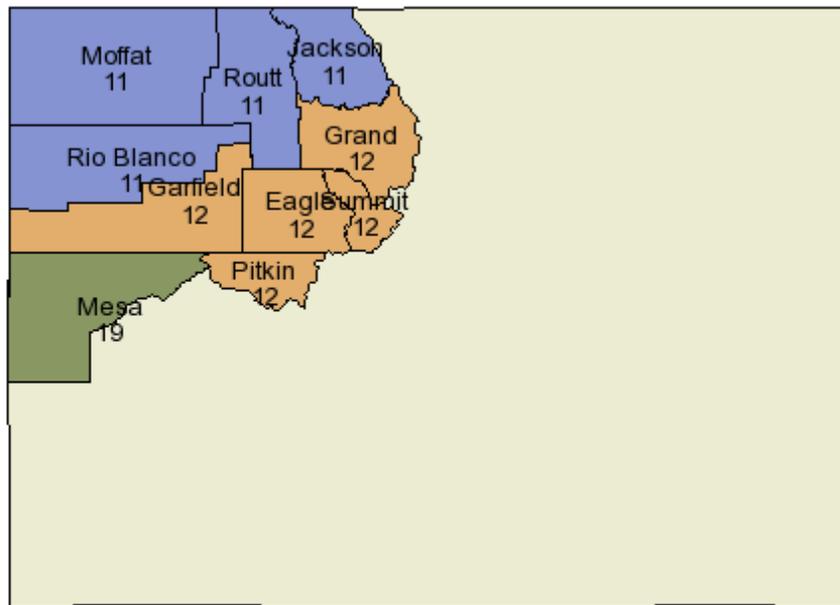
Both Regions 01 and 05 experienced periodic fluctuation trends. While the penetration rates for Regions 05 and 06 were trending downward as of June 2015, a similar decrease was present in March 2014. This indicates that such fluctuation may be normal.

Taken together with the periodic shifts in utilizer and provider count, there is no access issue identified in these HSRs.

HSRs 11, 12, and 19

Health Statistic Regions 11, 12, and 19 are comprised of residents from the north-western part of the State. These three regions reported approximately 297,000 insured persons in 2013, and grew to approximately 321,000 insured persons by 2015.

Predominately rural and mountainous, with one major urban center, these HSRs account for approximately 5.8% of the State's overall population.



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Figure 128 - Diagram of HSRs 11, 12, 19

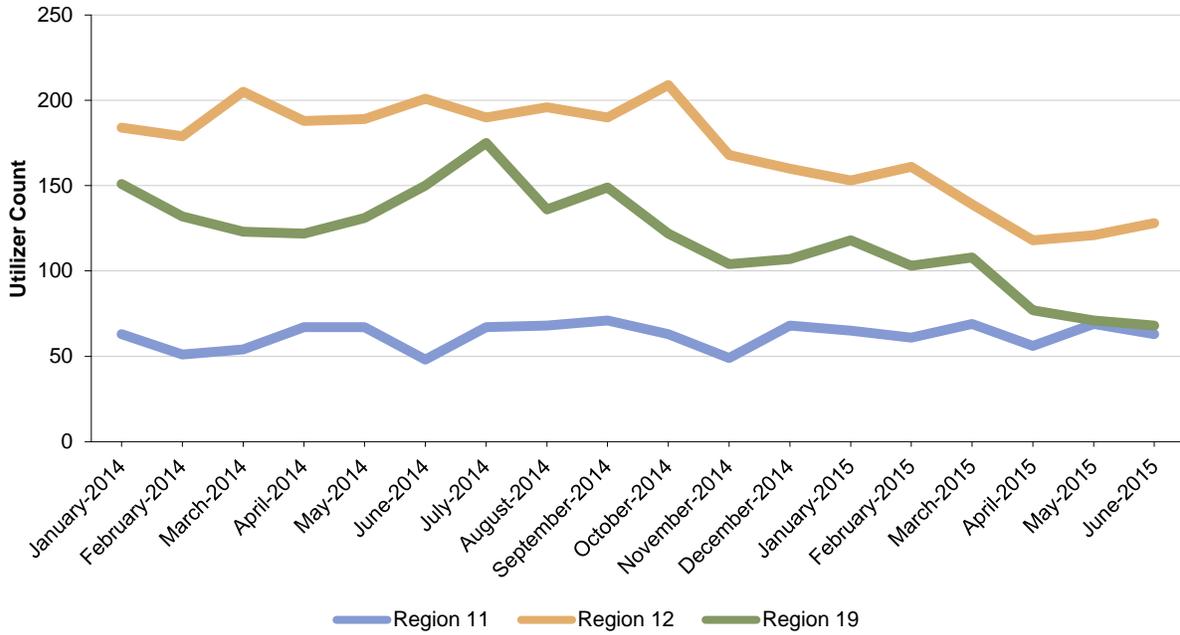


Figure 129 - Obstetric Services utilizer count, HSRs 11, 12, 19

The utilizer counts for these regions appear to fluctuate throughout 2014 and 2015, with slight decreases beginning in early 2015.

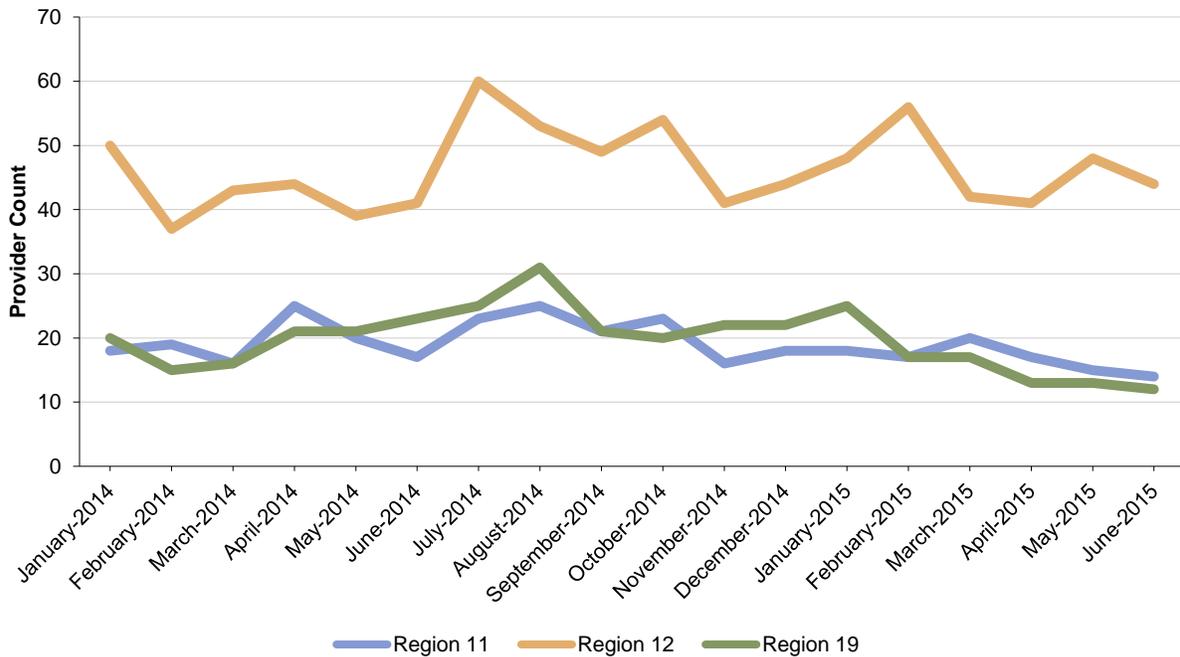


Figure 130 - Obstetric Services provider count, HSRs 11, 12, 19

The provider counts appear stable, with larger numbers in Region 12 than in Regions 11 and 19. This aligns with CHAS data, which reports a larger payer population (almost 40% higher) in Region 12

compared to Regions 11 and 19 combined.

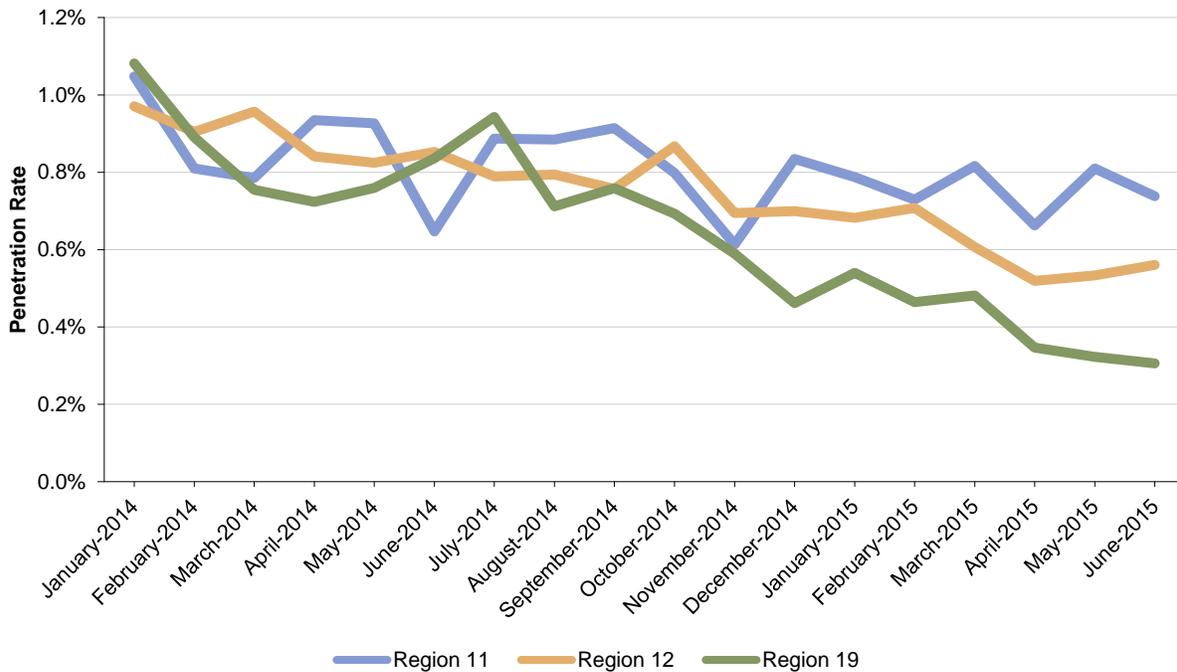


Figure 131 - Obstetric Services penetration rate, HSRs 11, 12, 19

Penetration rates for these regions appear to fluctuate over time, with decreases in utilization beginning in December 2014.

Analysis for HSRs 11, 12, and 19

All regions showed periodic fluctuations in their trends. HSR 19 statistics are explained in this manner:

1. Steady decline in penetration rate from 0.9% to 0.3% in an 18 month period.
2. Much lower reported rates of prenatal care delivery than from other insured persons (per the prenatal care data later in this analysis)
3. Steady decline in provider count

All three of these trends were the result of utilization shifting to a newly created delivery system, Rocky Mountain Health Plan (RMHP) Prime³³. The utilization of Health First Colorado benefits, provided by RMHP, is not included in this report because it is through a managed care delivery model. Therefore the trend statistics are somewhat misleading at first glance.

The timing for the observed changes in penetration rates within Region 19 (Mesa County) matches the change in enrollment, when all eligibility categories were able to voluntarily enroll with RMHP, to a process where most adults are passively enrolled in RMHP Prime, and most children are passively enrolled within a Medicaid fee-for-service payment model. This shift in enrollment is also true for

³³ Refer to pages 48-49 for a detailed explanation of how the move to the RMHP managed care program impacted these trends.

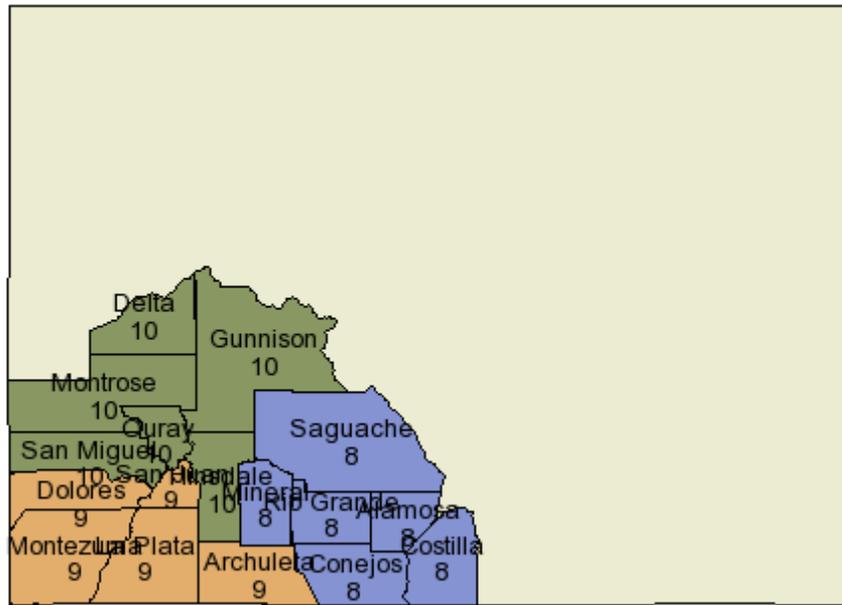
Montrose and Rio Blanco counties, however, this change is likely not as evident as these counties are within a larger multi-county region.

Given variations over time in other regions, fluctuation in HSRs 11 and 12 appear normal. Taken together with the periodic shifts in utilizer and provider count, there is no access issue identified in HSRs 11 and 12.

HSRs 08, 09 and 10

Health Statistic Regions 08, 09, and 10 are comprised of residents from the south-western part of the State. These three regions reported approximately 196,000 insured persons in 2013, and grew to approximately 199,000 insured persons by 2015.

Predominately rural and mountainous, these HSRs account for approximately 3.6% of the State's overall population.



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Figure 132 - Diagram of HSRs 08, 09, 10

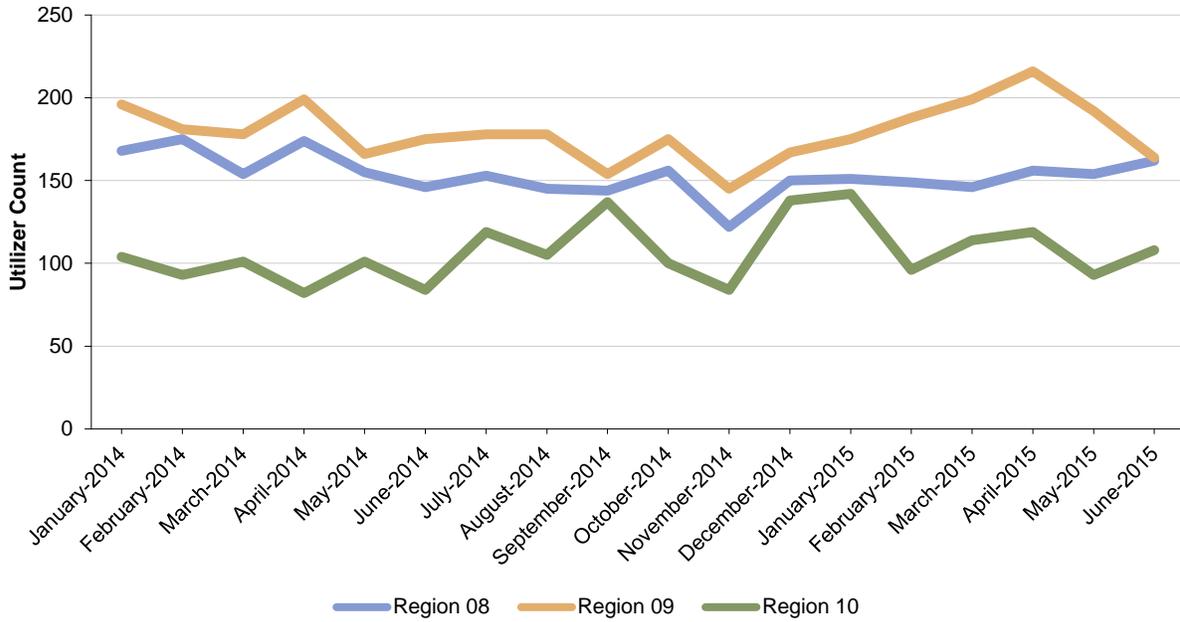


Figure 133 - Obstetric Services utilizer count, HSRs 08, 09, 10

The utilizer counts in these HSRs appear to fluctuate periodically year-over-year. According to CHAS data, these regions all report having very similar amounts of insured persons, including Medicaid members.

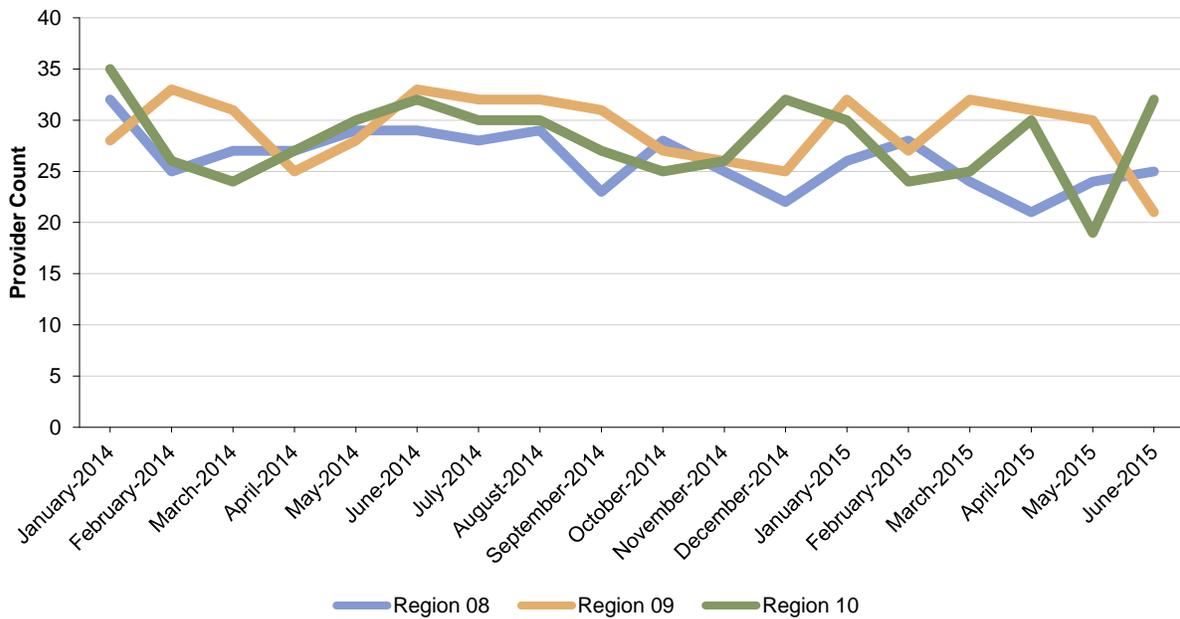


Figure 134 - Obstetric Services provider count 08, 09, 10

Similar to the utilizer counts, all three regions appear to have had relatively similar provider counts that tended to fluctuate month to month. In general however, the trend line remained relatively stable during the 18 month monitoring period shown.

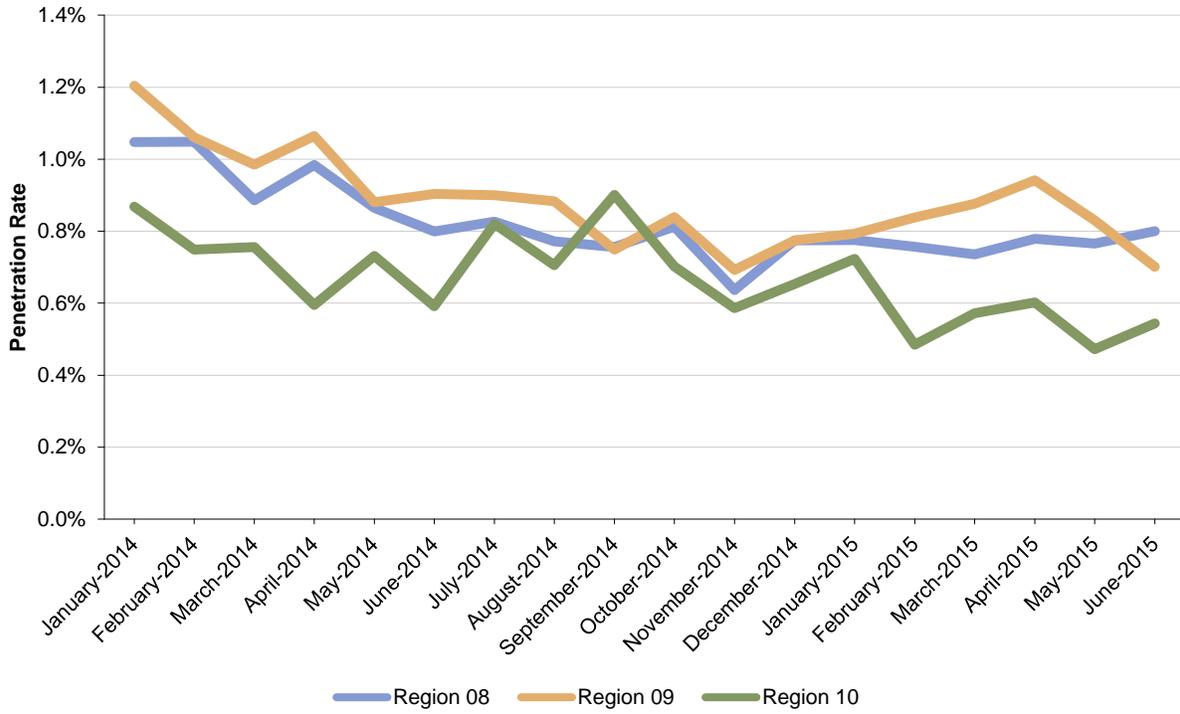


Figure 135 - Obstetric Services penetration rate, HSRs 08, 09, 10

Penetration rates appear to trend along with utilizer and provider counts and appear to show a moderate decrease from January 2014 to June 2015.

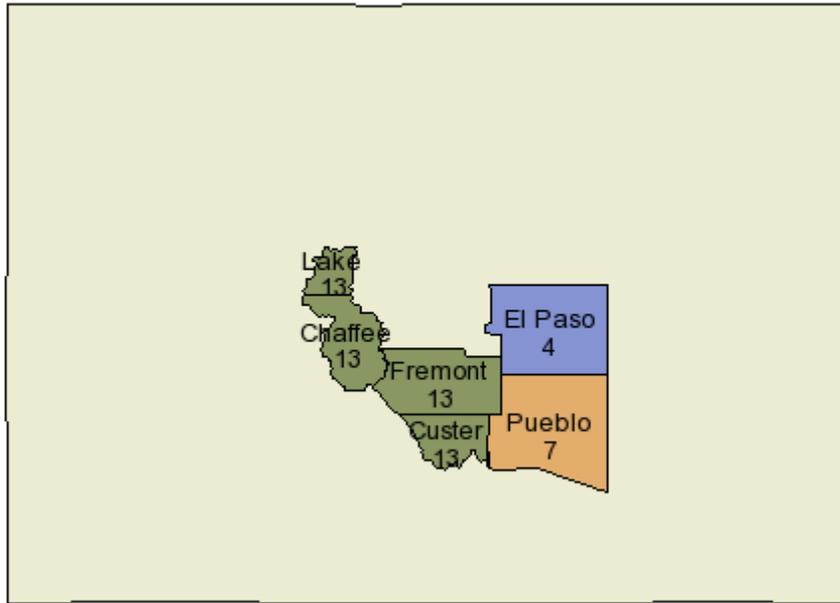
Analysis for HSRs 08, 09, and 10

All regions experienced periodic trend fluctuation. While the penetration rate for HSR 09 was trending downward as of June 2015, HSRs 10 and 08 were trending upwards. Taken together with the periodic shifts in utilizer and provider count, there is no access issue identified in these HSRs.

HSRs 04, 07, and 13

Health Statistic Regions 04, 07, and 13 are comprised of residents in the central to southern part of the State. These three regions reported approximately 750,000 insured persons in 2013, and grew to approximately 800,000 insured persons by 2015.

A mix of urban and rural with some mountainous regions, these HSRs account for approximately 14.6% of the State's overall population.



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Figure 136 - Diagram of HSRs 04, 07, 13

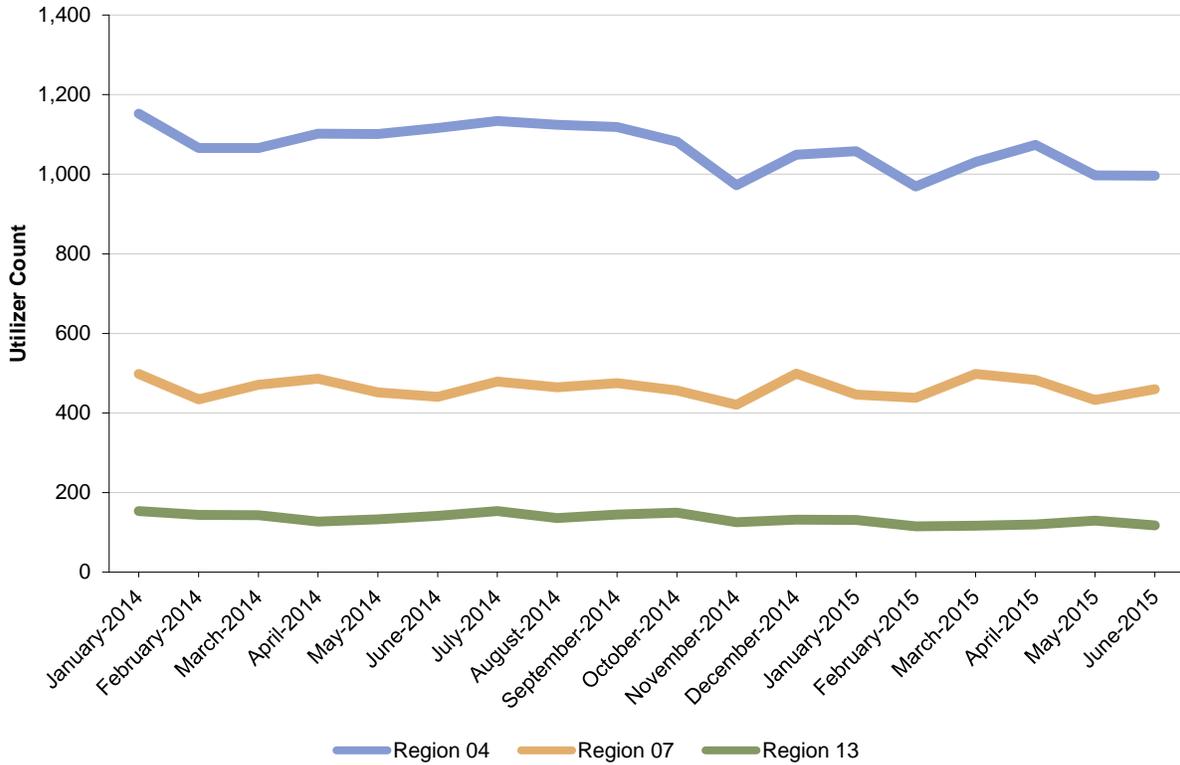


Figure 137 - Obstetric Services utilizer count, HSRs 04, 07, 13

The utilizer counts for these regions remain relatively stable year-over-year. Region 04 appears higher than Regions 07 and 13. This appears to align with CHAS data, which reports Region 04 as having approximately seven times the payer population that that of Regions 07 and 13.

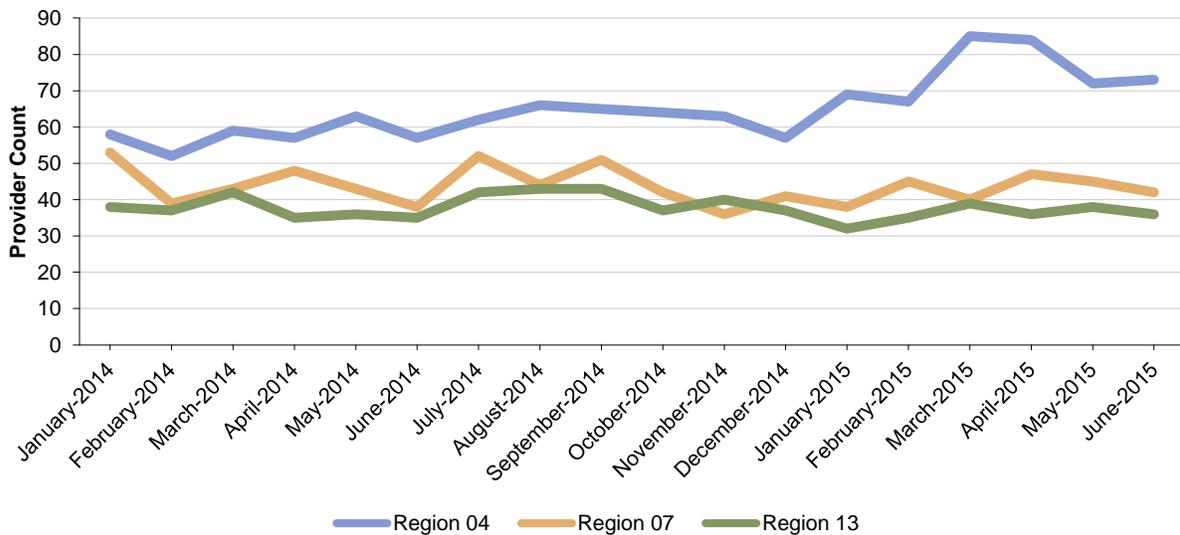


Figure 138 - Obstetric Services provider count, HSRs 04, 07, 13

The provider counts also appear relatively stable, with larger numbers in Region 04. This aligns with the utilizer count fluctuations.

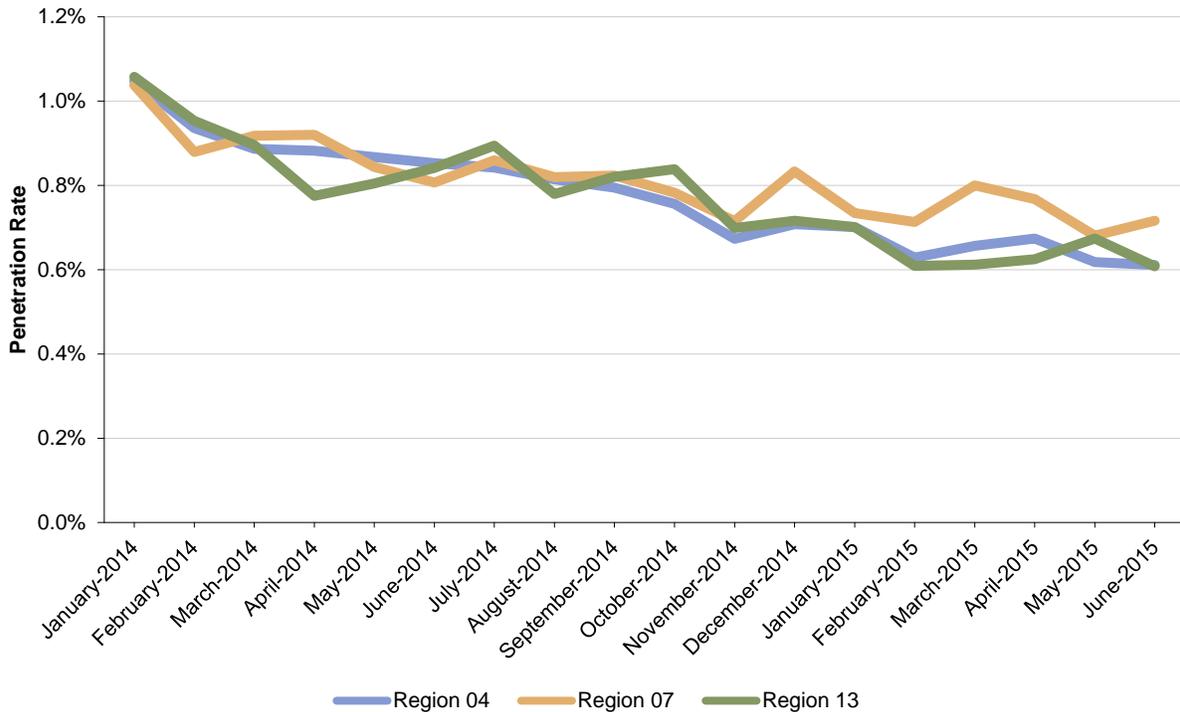


Figure 139 - Obstetric Services penetration rate, HSRs 04, 07, 13

In general, penetration rates remain stable with mild fluctuations from month to month. There also appears to have been a moderate decline in utilization from January 2014 to June 2015.

Analysis for HSRs 04, 07, and 13

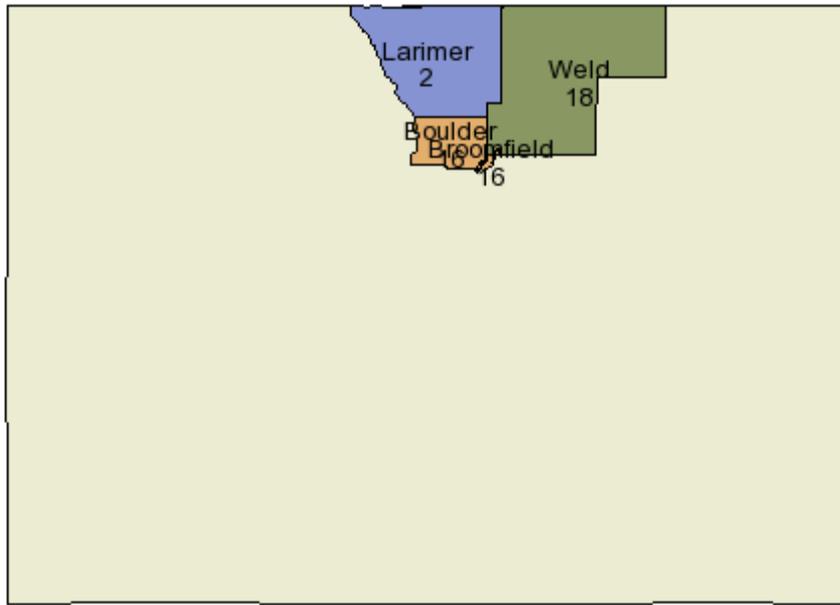
All regions experienced periodic fluctuation trends. While the penetration rates for HSRs 13 and 04 were trending slightly downward as of June 2015, HSR 07 was increasing.

These penetration rates may normalize over time and appear to be within normal expected fluctuation ranges. There is no access issue identified in these HSRs.

HSRs 02, 16, and 18

Health Statistic Regions 02, 16, and 18 are comprised of residents in the central and northern part of the State. These three regions reported approximately 770,000 insured persons in 2013, and grew to approximately 825,000 insured persons by 2015.

Predominately rural and somewhat mountainous, with numerous urban centers, these HSRs account for approximately 15.1% of the State's overall population.



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Figure 140 - Diagram of HSRs 02, 16, 18

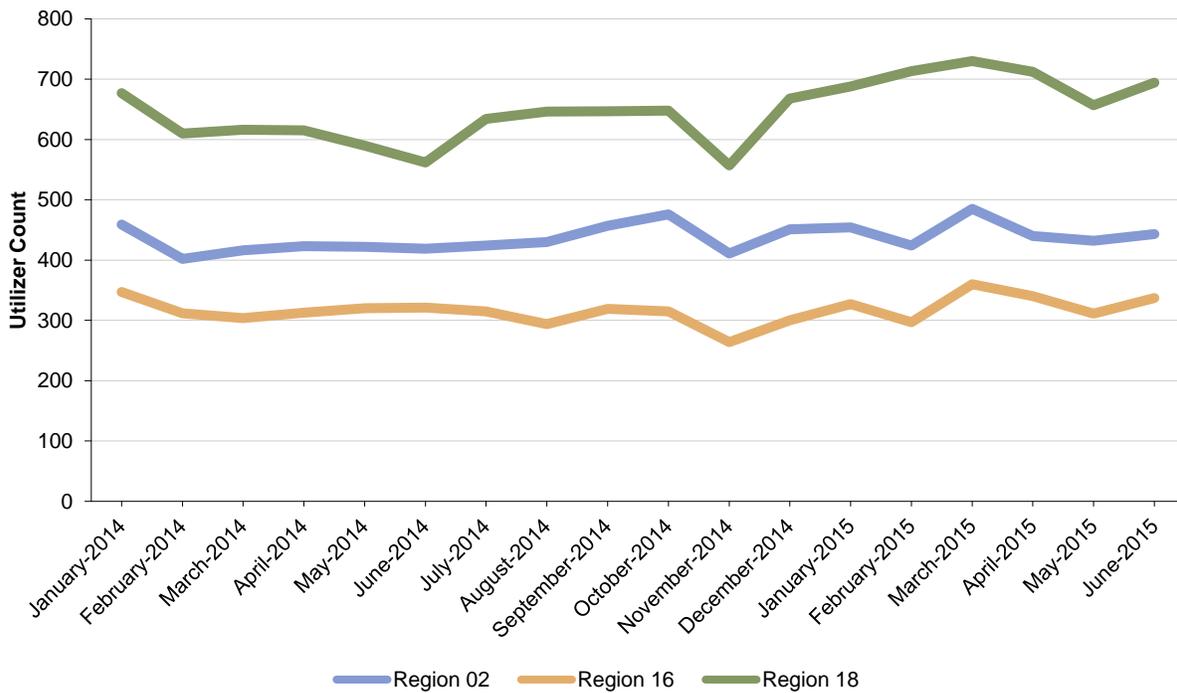


Figure 141 - Obstetric Services utilizer count, HSRs 02, 16, 18

The utilizer counts for these regions appear relatively stable year-over-year, with a mild increase in Region 18 beginning in December 2014.

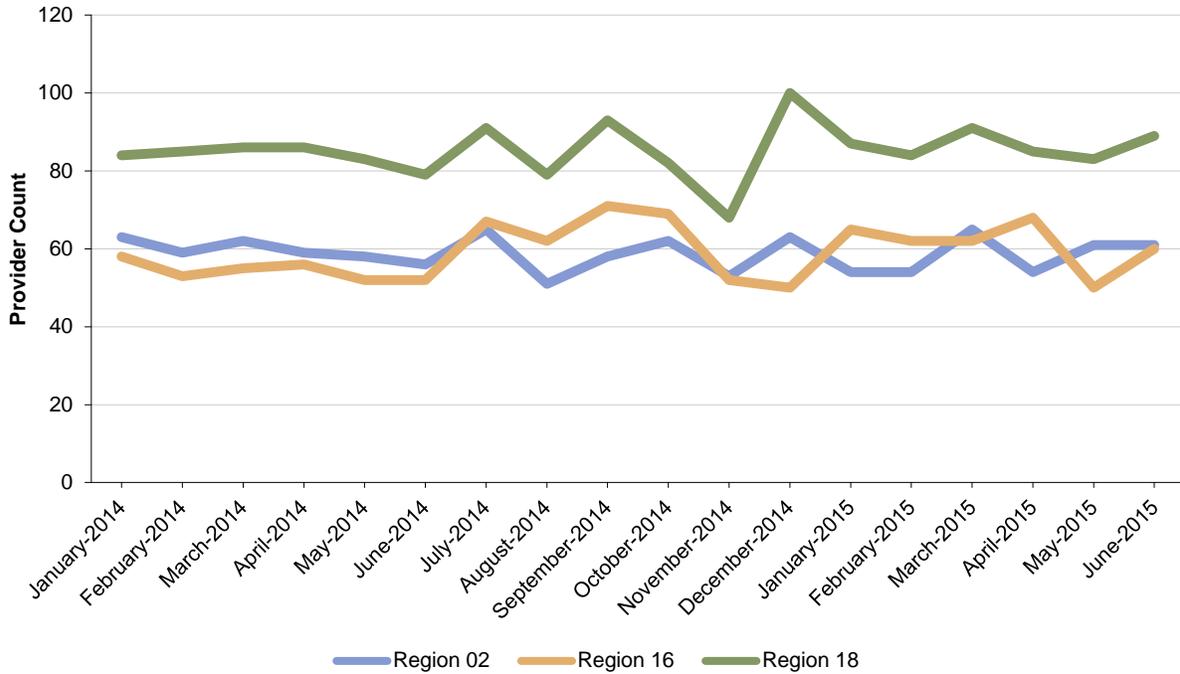


Figure 142 - Obstetric Services provider count, HSRs 02, 16, 18

Similarly, provider counts appear stable year-over-year, with moderate monthly fluctuations. And as was the case with utilizer counts, Region 18 reported larger numbers of providers than Regions 02 and 16, however the difference is minimal.

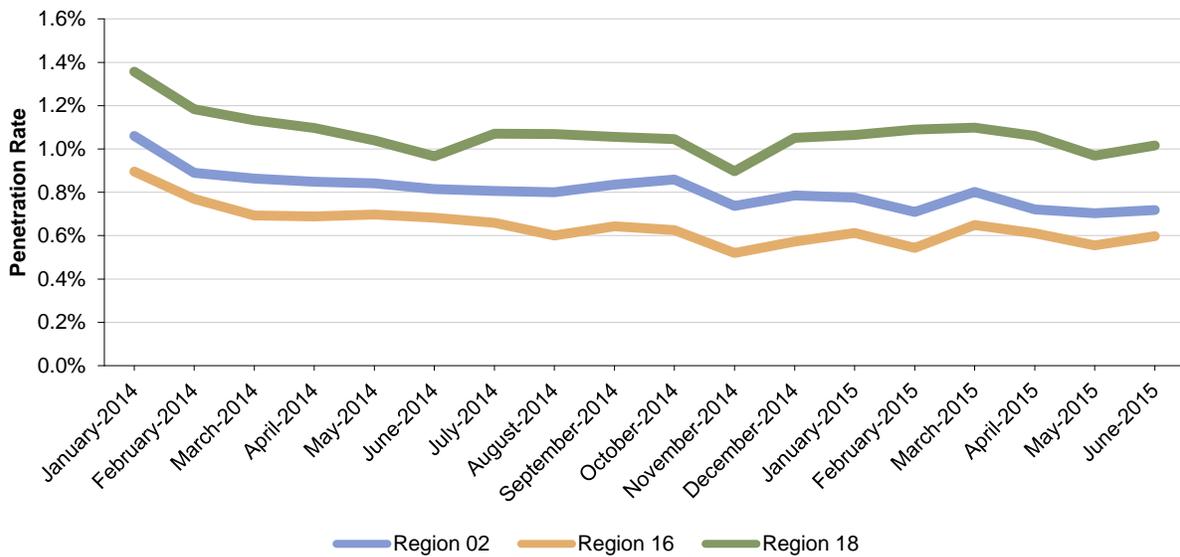


Figure 143 - Obstetric Services penetration rate, HSRs 02, 16, 18

The penetration rates for these regions have been largely stable since March 2014.

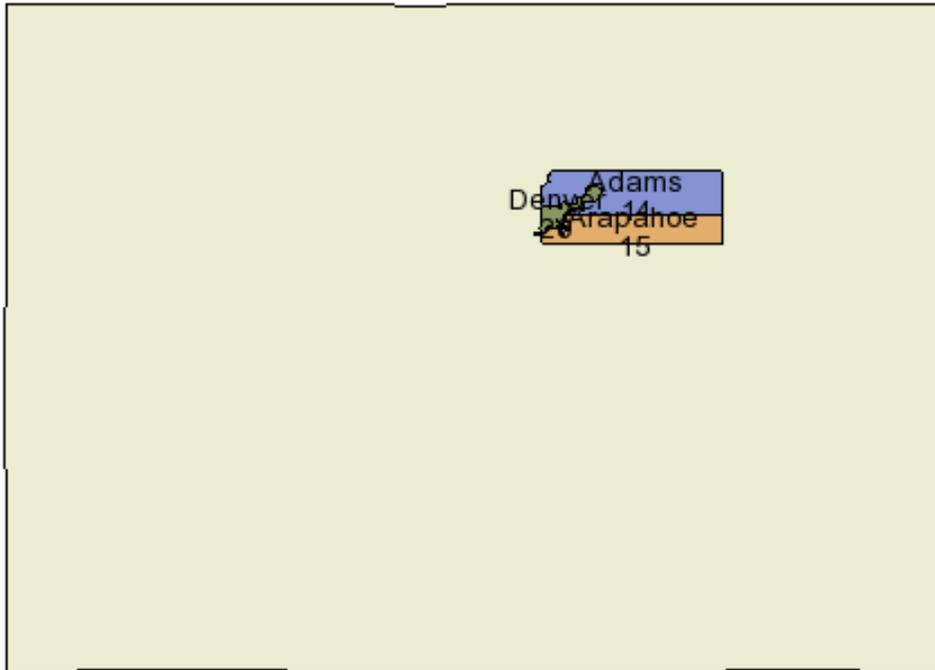
Analysis for HSR 02, 16, and 18

All regions experienced periodic fluctuation trends. Based on this data, no access issue were identified in these HSRs.

HSRs 14, 15, and 20

Health Statistic Regions 14, 15, and 20 are comprised of residents in the central part of the State. These three regions reported approximately 1,333,000 insured persons in 2013, and grew to approximately 1,377,000 insured persons by 2015.

Predominately urban, geographically, these HSRs account for approximately 25.2% of the State's overall population.



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Figure 144 - Diagram of HSRs 14, 15, 20

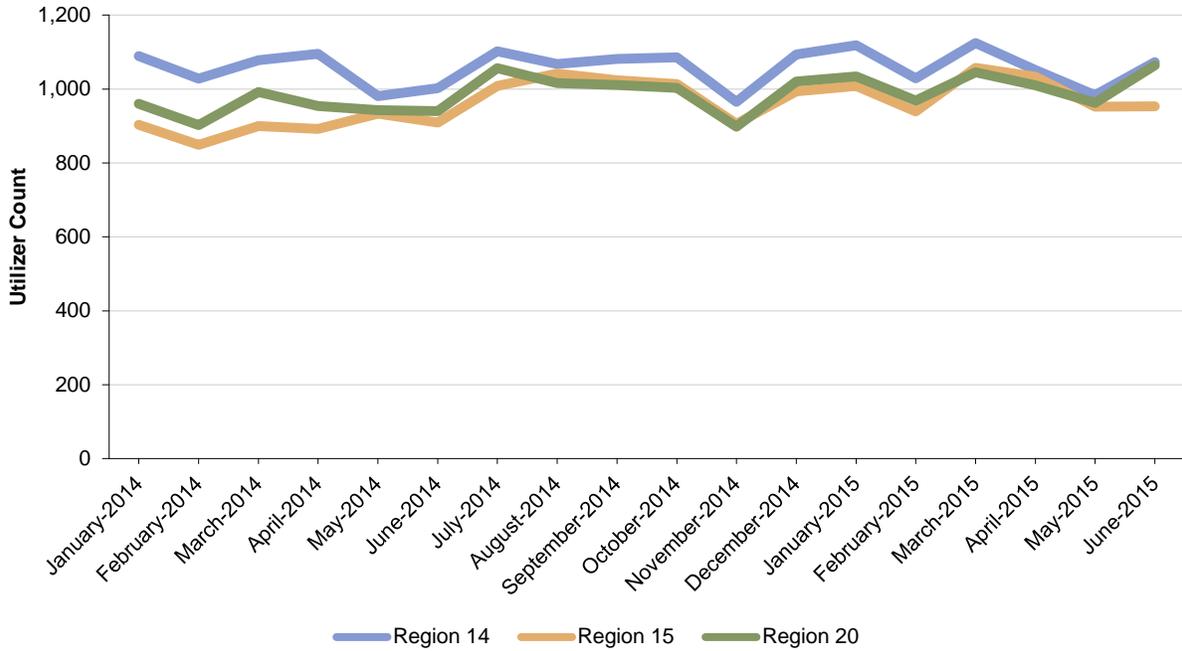


Figure 145 - Obstetric Services utilizer count, HSRs 14, 15, 20

In general, utilizer counts remained relatively stable in Regions 14, 15 and 20, with a slight increase year-over-year.

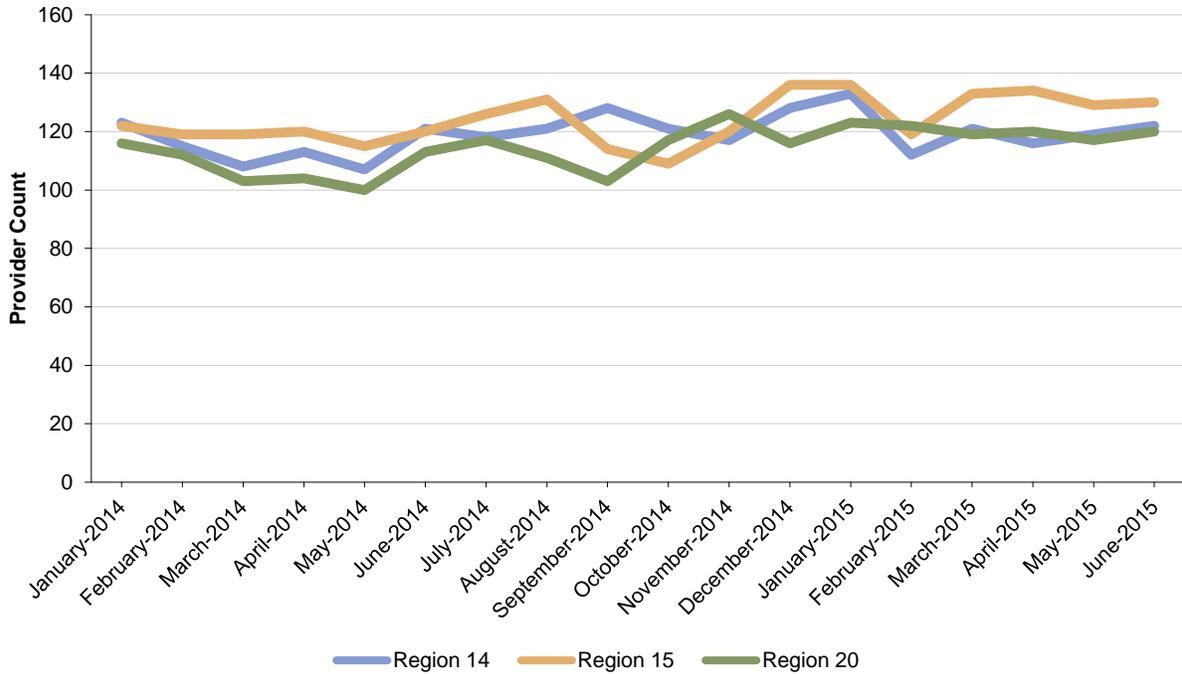


Figure 146 - Obstetric Services provider count, HSRs 14, 15, 20

Similar to utilizer count, provider counts appears stable and also experienced a slight increase from January 2014 to June 2015.

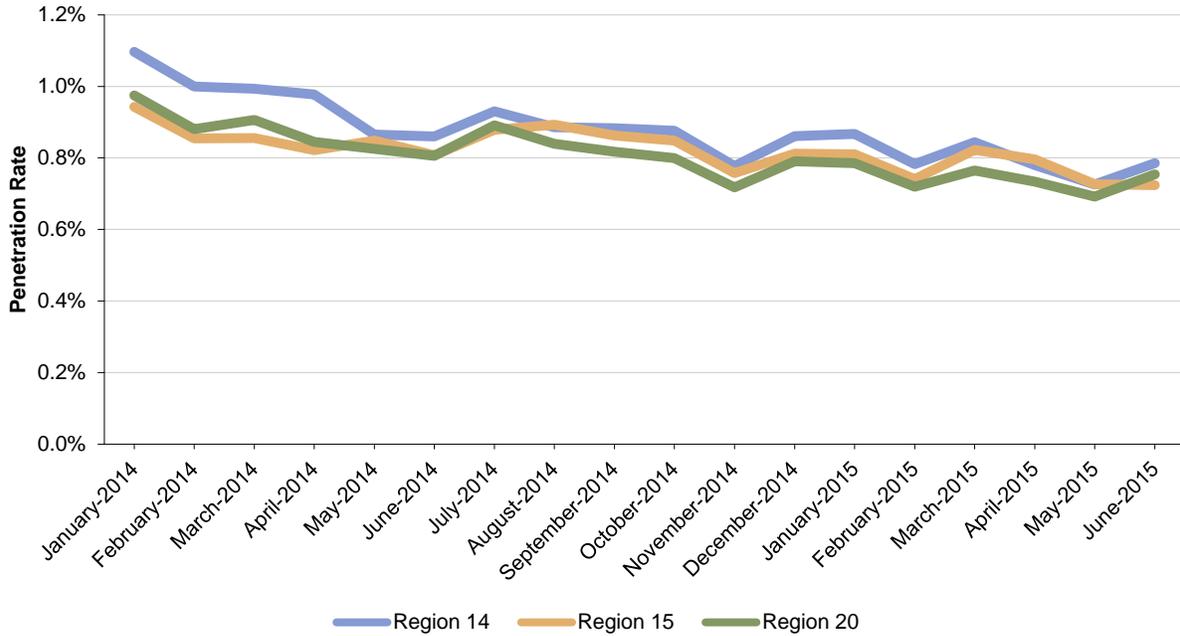


Figure 147 - Obstetric Services penetration rate, HSRs 14, 15, 20

While penetration rates appear stable, with mild monthly fluctuations, there appears to have been a slight decrease in utilization year-over-year.

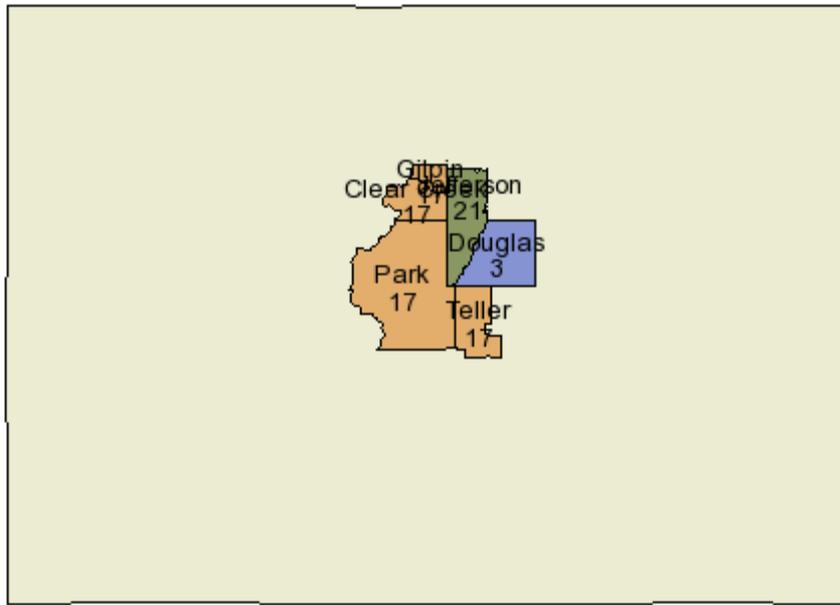
Analysis for HSRs 14, 15, and 20

All regions experienced periodic fluctuation trends. The penetration rates for these regions have been largely stable since March 2014. There is no access issue identified in these HSRs.

HSRs 03, 17, and 21

Health Statistic Regions 03, 17, and 21 are comprised of residents in the central part of the State. These three regions reported approximately 79,000 insured persons in 2013, and grew to approximately 876,000 insured persons by 2015.

A mix of urban and rural geography, these HSRs account for approximately 16% of the State's overall population.



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Figure 148 - Diagram of HSRs 03, 17 21

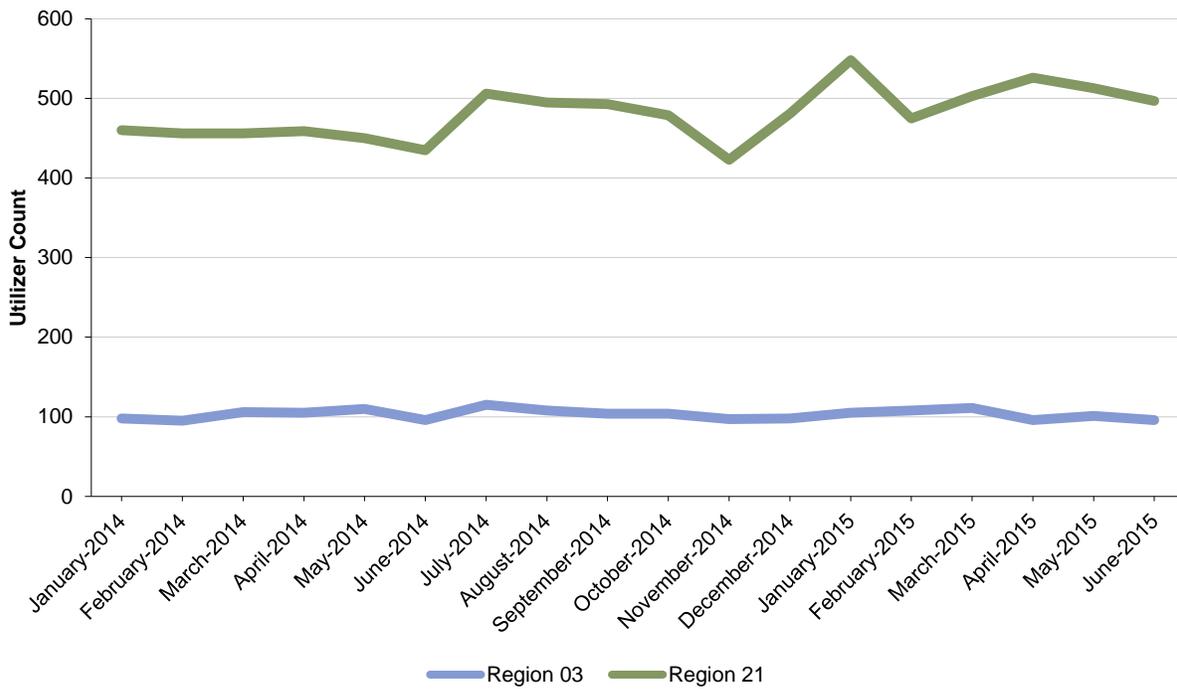


Figure 149 - Obstetric Services utilizer count, HSRs 03, 21

The utilizer count is larger in Region 21 than the other regions. This aligns with CHAS data, which reports Region 21 as having approximately three times the amount of Medicaid members than Region 03. HSR 17 has been blinded per HIPAA requirements.

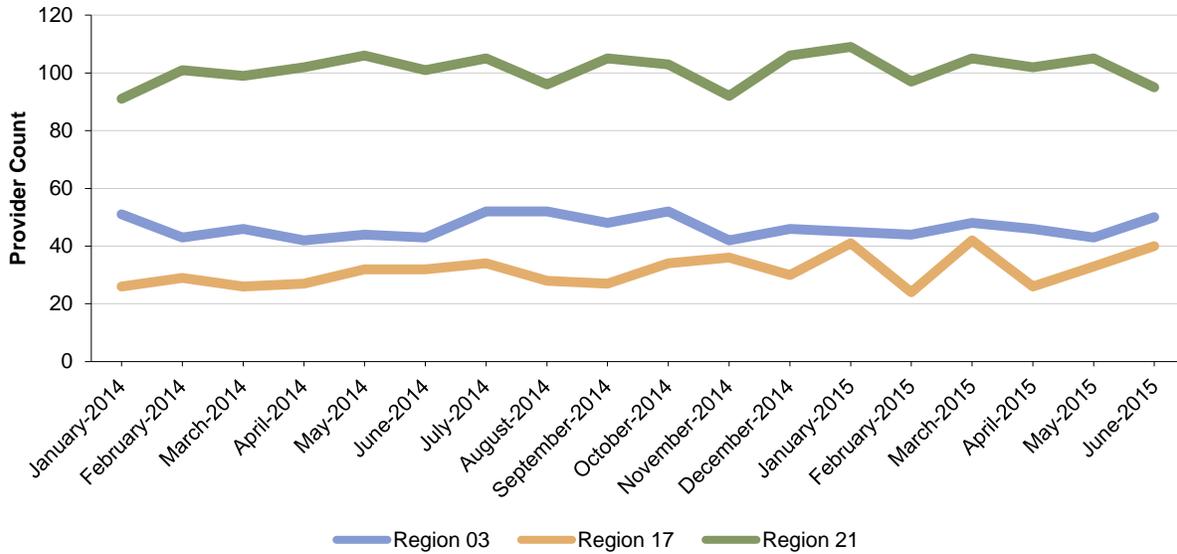


Figure 150 - Obstetric Services provider count, HSRs 03, 17, 21

The provider count for Region 21 was greater than that of Regions 03 and 17. This again aligns with CHAS data, which reports Region 21 as having approximately nine times as many insured persons than Region 03, and approximately two times as many that Region 17.

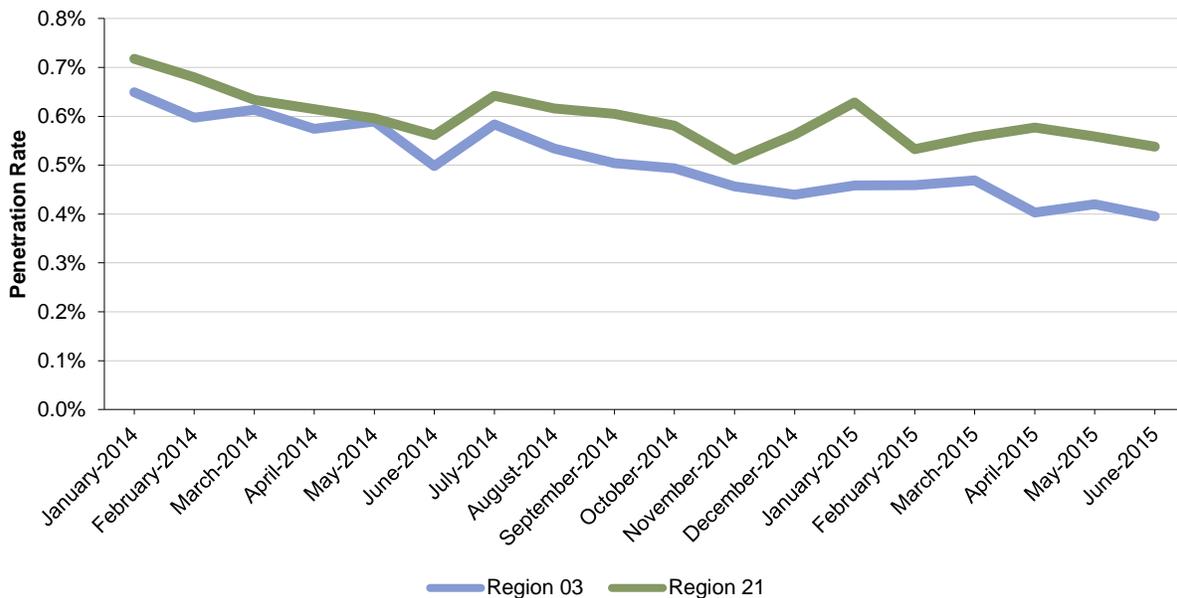


Figure 151 - Obstetric Services penetration rate, HSRs 03, 21

Penetration rates remained largely stable for HSRs 03 and 21 in 2015, this deviation is not outside of normal fluctuation. HSR 17 has been blinded per HIPAA requirements.

Analysis for HSRs 03, 17, 21

Even though the penetration rate steadily fell during the examined time period, when taken into consideration with the stable active provider count, it does not indicate an access issue. These statistics do not indicate an access issue.

Obstetric Services Analysis by Provider Type and Site of Service

Figures 152 and 153 are FY 2014-15 snapshots of Billing Provider type by utilizer count. They depict the distribution of billing provider types within the service category who deliver the benefit. *Fulfills requirement 42 CFR 447.203(b)(1)(ii)*

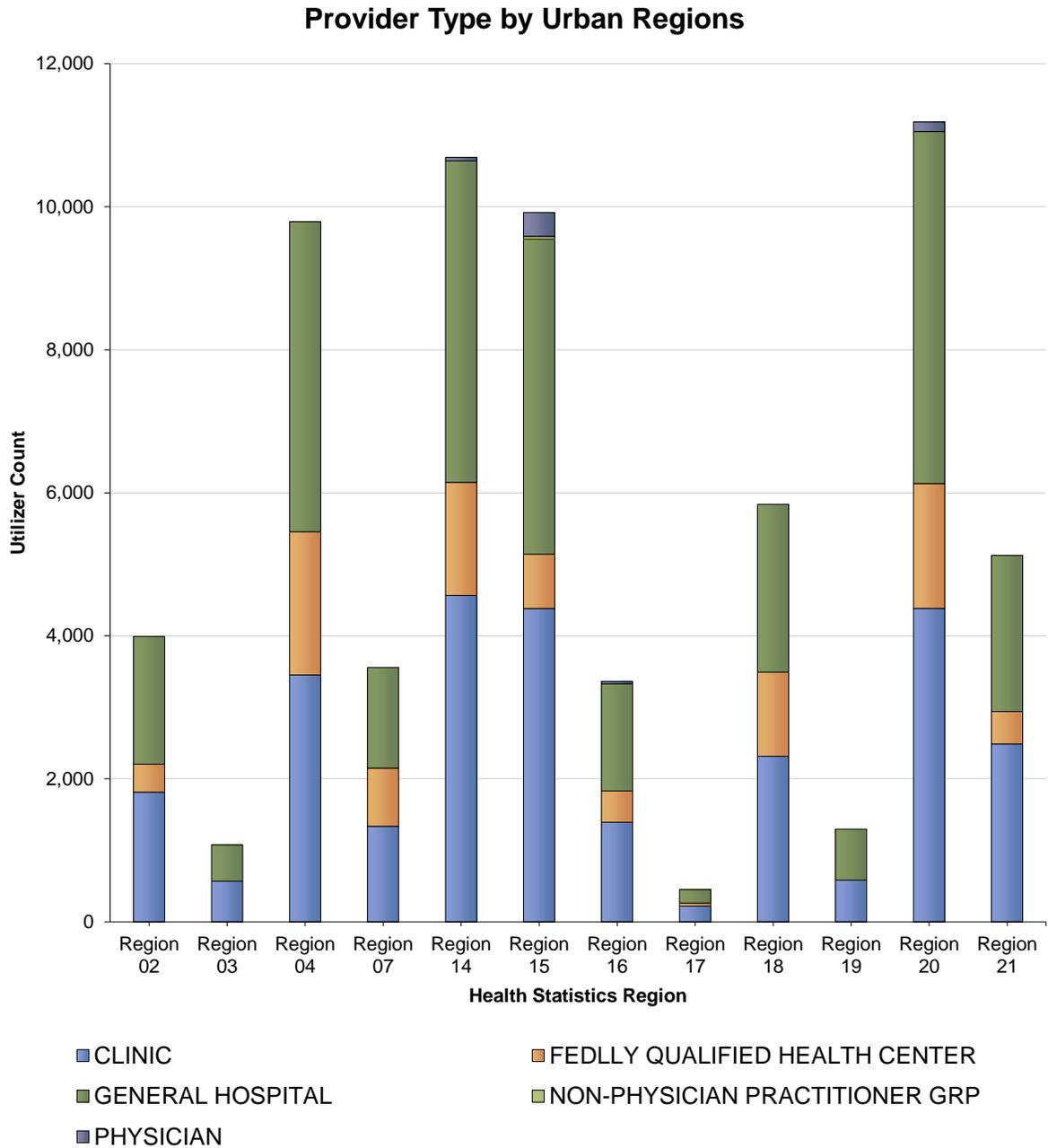


Figure 152 - Obstetric Services provider type by urban HSRs

Provider Type by Rural Regions

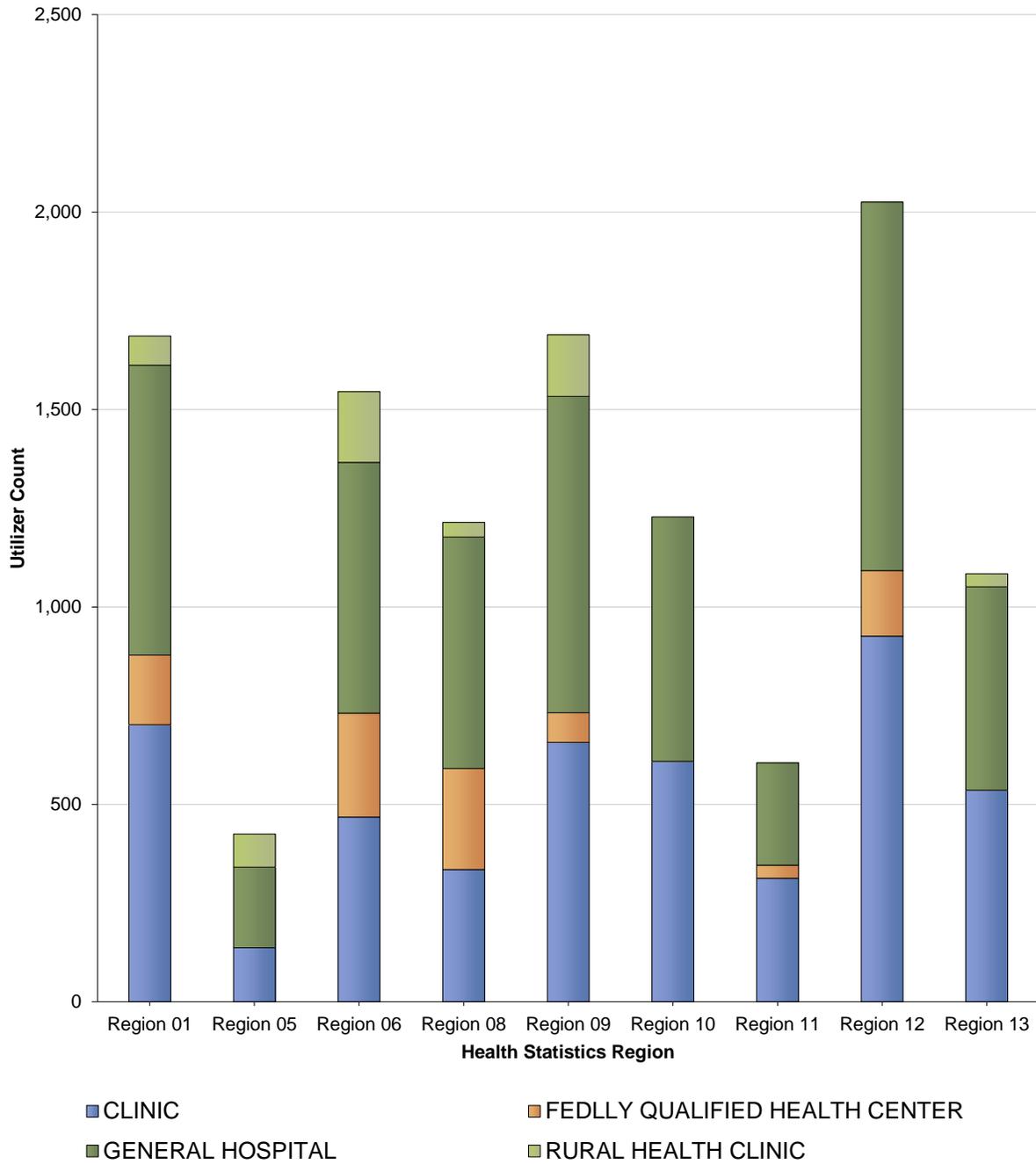


Figure 153 - Obstetric Services provider type by rural HSRs

Analysis of Provider Type

The benefit is delivered by a variety of provider types across HSRs, consistent with the needs of obstetric care, which include office visits and hospital delivery. FQHCs only show utilization within the HSR where they are stationed, therefore, the lack of their presence in HSR 5, 10, and 13 does not indicate an access issue as services were delivered by the other provider groups.

Figures 154 and 155 are FY 2014-15 snapshots of Place of Service by utilizer count. They depict the distribution of place of service (the setting where the benefit was delivered) within the service category. *Fulfills requirement 42 CFR 447.203(b)(1)(ii)*

Place of Service by Urban Regions

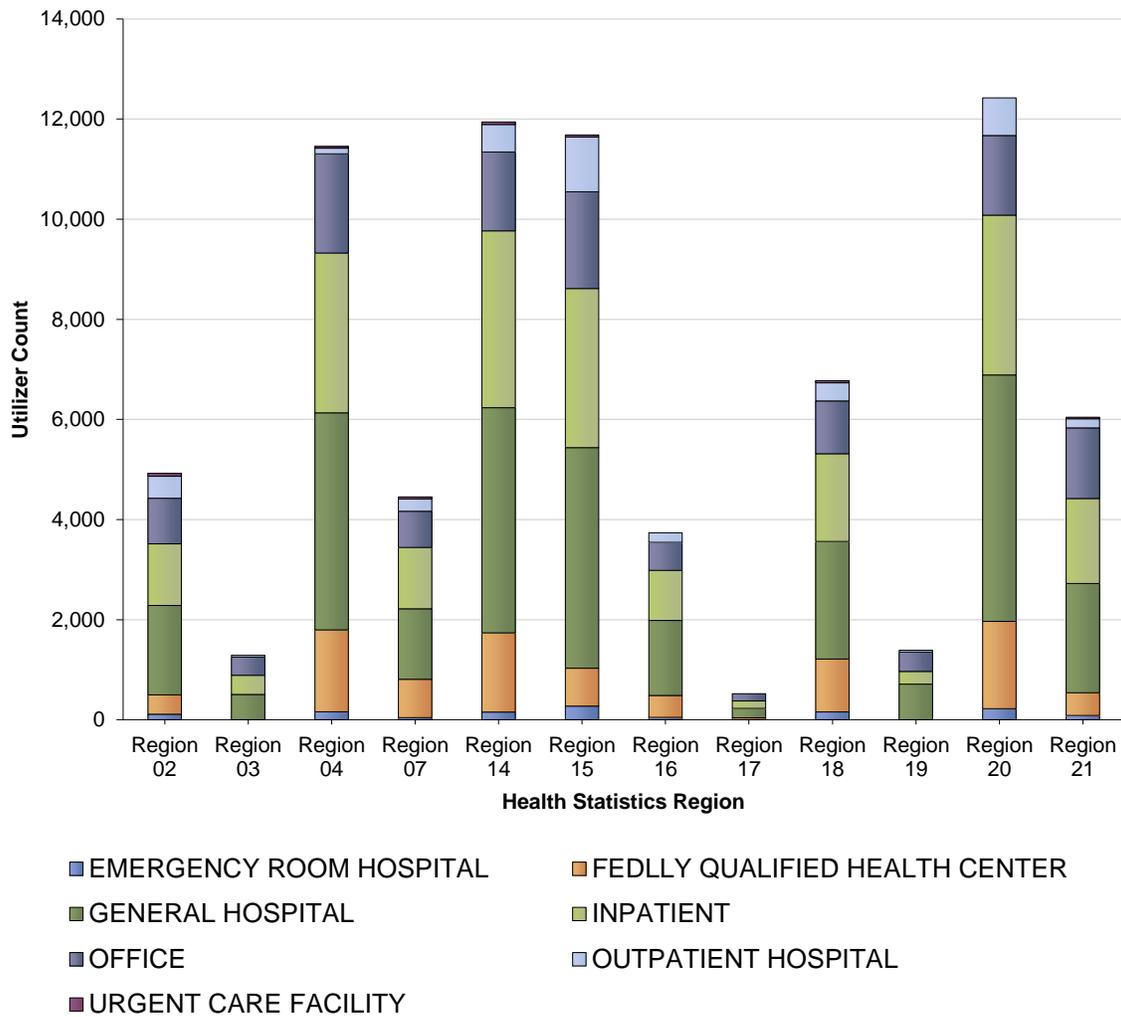


Figure 154 - Obstetric Services place of service by urban HSRs

Place of Service by Rural Regions

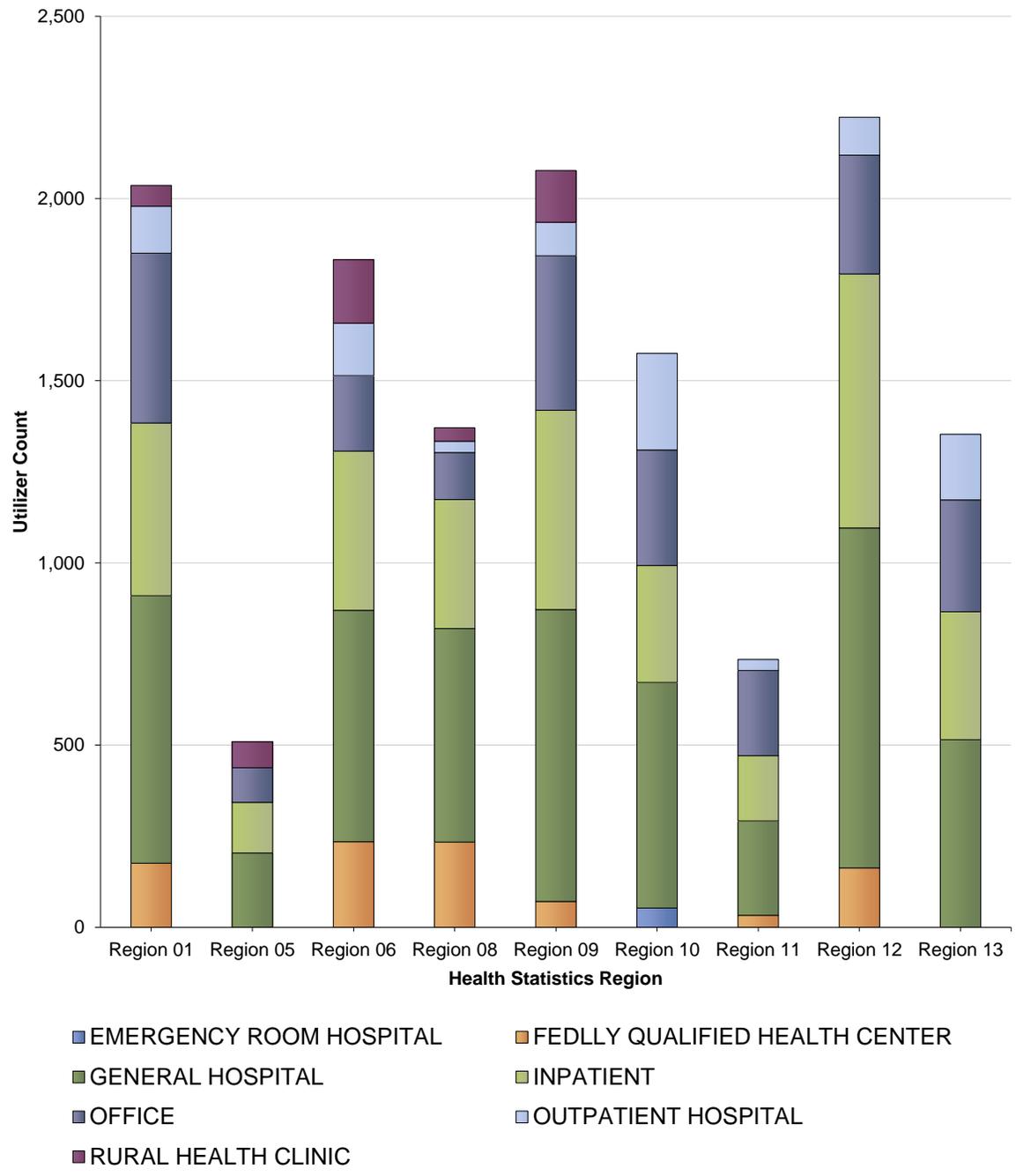


Figure 155 - Obstetric Services place of service by rural HSRs

Analysis for Place of Service

Utilizers of this benefit access care in a variety of places of service, consistent with the needs of obstetric care and geographical location.

Obstetric Services Prenatal Care Statistics

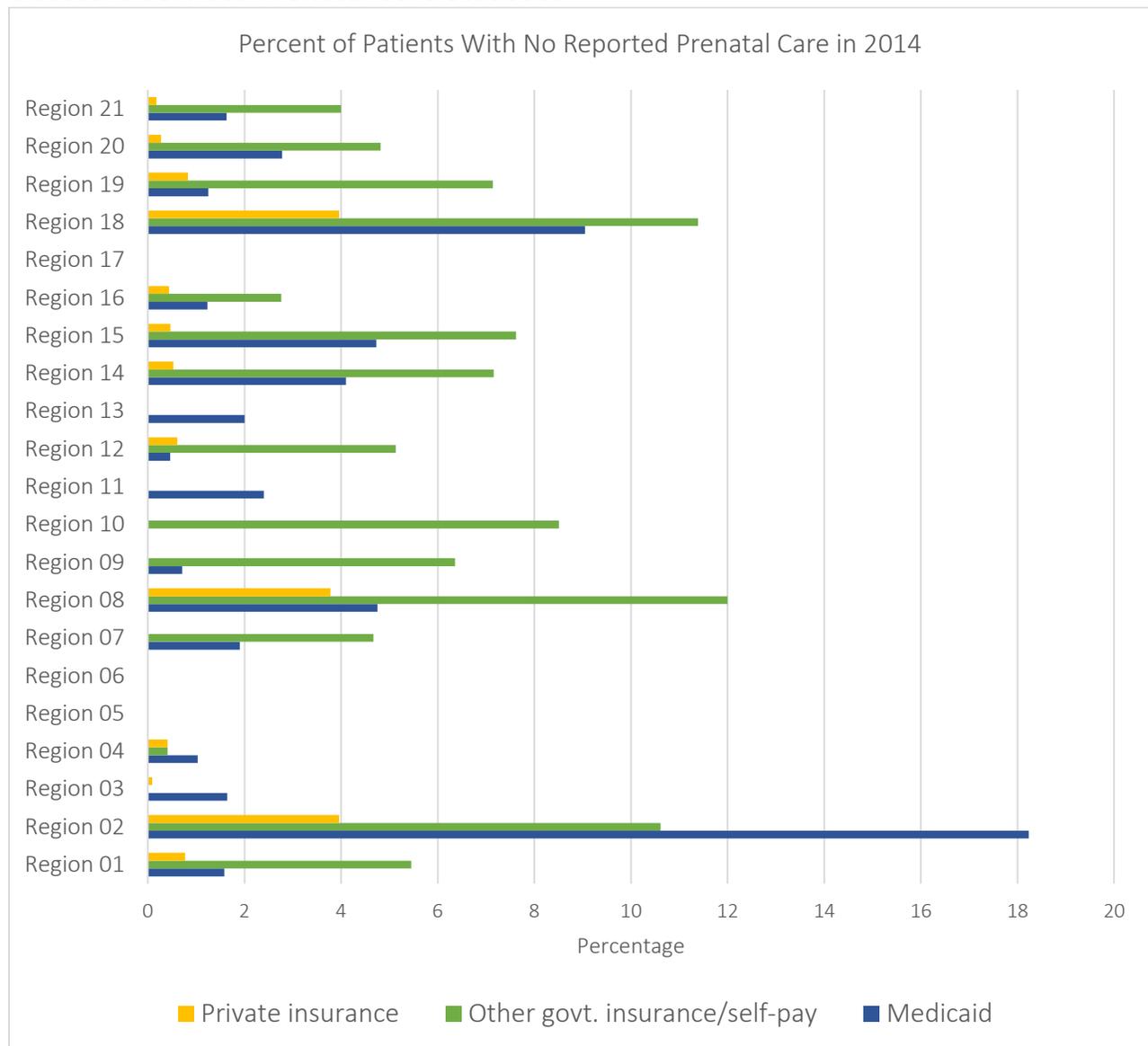


Figure 156 - Obstetric Services Prenatal care statistics, by HSR

While, nationally, Medicaid members tend to have lower rates of prenatal care, given the above noted threshold penetration rates for some regions, data in Figure 156 may not accurately reflect access to prenatal care. Rather, it may indicate member utilization rates.

Obstetric Services Colorado Health Access Survey Data

No 2015 CHAS data pertinent to this service was available.

Obstetric Services Rate Comparison – Actual or Estimated Levels of Provider Payment

Fulfills requirement 42 CFR 447.203(b)(1)(v)

In aggregate, the 2016 Health First Colorado rates for Obstetric Services varied by place of service based on the top 50 procedure codes used to bill for services. Of the top 50 codes, the Department identified at least 10 Medicaid and private payer codes in the CIHVC data (from the Colorado All Payer Claims Database) that matched and could be used comparative analysis. Available Medicare codes did not differentiate by place of service, therefore the average of all top codes for all places of service was used for comparative analysis.

This table displays the percentage Medicaid rates differ from private payers (CIVHC difference) and Medicare. For example, Medicaid rates are 35.32% below Medicare. The wide difference in CIVHC rate percentages below reflect the different codes that were both available and were most commonly used. Each place of service had different commonly used codes available.

Place of Service	CIVHC % Difference	MEDICARE % Difference
Office	-43.77%	-35.32%
Urgent care facility	-1.99%	-35.32%
Inpatient hospital	-47.19%	-35.32%
Outpatient hospital	-58.30%	-35.32%
Emergency room -- hospital	-2.07%	-35.32%
Ambulatory surgical center	3.65%	-35.32%
Community mental health center	28.83%	-35.32%
Public health clinic	163.94%	-35.32%
Rural health clinic	1.51%	-35.32%
AVERAGE	4.96%	-35.32%

Table 11- Obstetric Services rate comparison table

Obstetric Services Input from Beneficiaries, Providers, and Stakeholders

Fulfills requirement 42 CFR 447.204(a)(2)

Fulfills requirement 42 CFR 447.204(b)(3) – as applicable under ‘Specific Analysis of Input from Stakeholders Affected by a Payment Restructure or Reduction’

Obstetric Services Direct-to-Staff Input

Department staff occasionally receive unsolicited input directly from beneficiaries, providers, and stakeholders concerning access to care for this service while performing their operational duties. Staff address and catalogue those access comments in accordance with the procedures detailed in the Access Monitoring Review Plan – Appendix A. The Department has received no direct-to-staff comments concerning access to care for this service.

Obstetric Services Targeted Stakeholder Input and Input from General Public Notice

A draft of this Plan was sent to key stakeholders and was made publically available on the Department’s website for 30 day public comment. Feedback and input was accepted through email and through an online survey and is summarized in Appendix K. Several stakeholders pointed to anomalies in the way the data and analysis above was originally presented. Where applicable, the Department has clarified within the body of the Plan.

Obstetric Services Access Issues Discovered As a Result of This Review

Fulfills requirements 42 CFR 447.203(b)(4)

This is a list of the Access Issues identified using the data available in this review. Data which suggests an Access Issue will be investigated and monitored for a period of two consecutive quarters to ensure the pattern is not an artifact or data anomaly. If investigation does reveal a deficit, the Access Issue becomes an Access Deficiency which triggers the process described in the Access Monitoring Review Plan – Appendix B (42 CFR 447.203(b)(8)).

There are no access issues identified as a result of this report.

Obstetric Services Extent to Which Beneficiary Needs Are Fully Met

Fulfills requirements 42 CFR 447.203(b)(1)(i)

Maternity services cover the duration of the pregnancy and the post-natal period and a variety of medically necessary services. Data showed that pregnant members were able to access a variety of providers and places of service across rural and urban areas. Utilizer demographics did not indicate an access issue and penetration rates were consistent across HSRs.

The Department's analytical conclusion is that Obstetric Services (including labor and delivery) are sufficient to enlist enough providers so that services are available at least to the extent they are available to the general population in each geographic area, pursuant to section 1902(a)(30)(A) of the Social Security Act.

Appendix J: Access Monitoring Analysis - Home Health Services

Fulfills requirement 42 CFR 447.203(b)(5)(ii)(E)

Home Health Services Definition of Service

Home Health Services consist of skilled nursing, certified nurse aide (CNA), physical (PT) and occupational therapy (OT), and speech/language pathology (SLP) services. Home Health is a mandatory State Plan benefit offered to Health First Colorado members who need intermittent skilled care. Providers that render Home Health Services must be employed by a licensed, class A Home Health agency. Home Health Services are divided into two service types: acute and long-term. Acute Home Health Services are provided for treatment of acute conditions and episodes (e.g., post-surgical care) for up to 60 days. Long-term Home Health Services are available to members who require ongoing Home Health Services beyond the 60-day acute Home Health period.

Home Health Services Characteristics of the Beneficiary Population

Fulfills requirements 42 CFR 447.203(b)(1)(iv)

Long-term Home Health Services require prior authorization. For members 20 years and younger, prior authorization requires an assessment, conducted via the Pediatric Assessment Tool (PAT), and the member's plan of care. For members ages 21 years and older, prior authorization requirements include meeting criteria outlined in the Department's Benefit Coverage Standard and meeting Long-Term Care 100.2 criteria. Through EPSDT, members ages 20 years and younger may receive PT, OT, and SLP in both acute and long-term Home Health service periods, while members ages 21 years and older may only receive PT, OT, and SLP Home Health Services for acute periods. Available services and payments do not vary by geographic locations throughout the State.

Medicaid members access this benefit by receiving an assessment and care from a licensed and certified class A Home Health agency.

Home Health Services Administrative Claims Utilization Data

Figure 157 is a FY 2014-15 snapshot of demographic groups (children/adults/individuals with disabilities) by utilizer count. This depicts the demographic group distribution of service utilizers, which informs the Beneficiary Characteristic description. *Fulfills requirement 42 CFR 447.203(b)(1)(iv)*

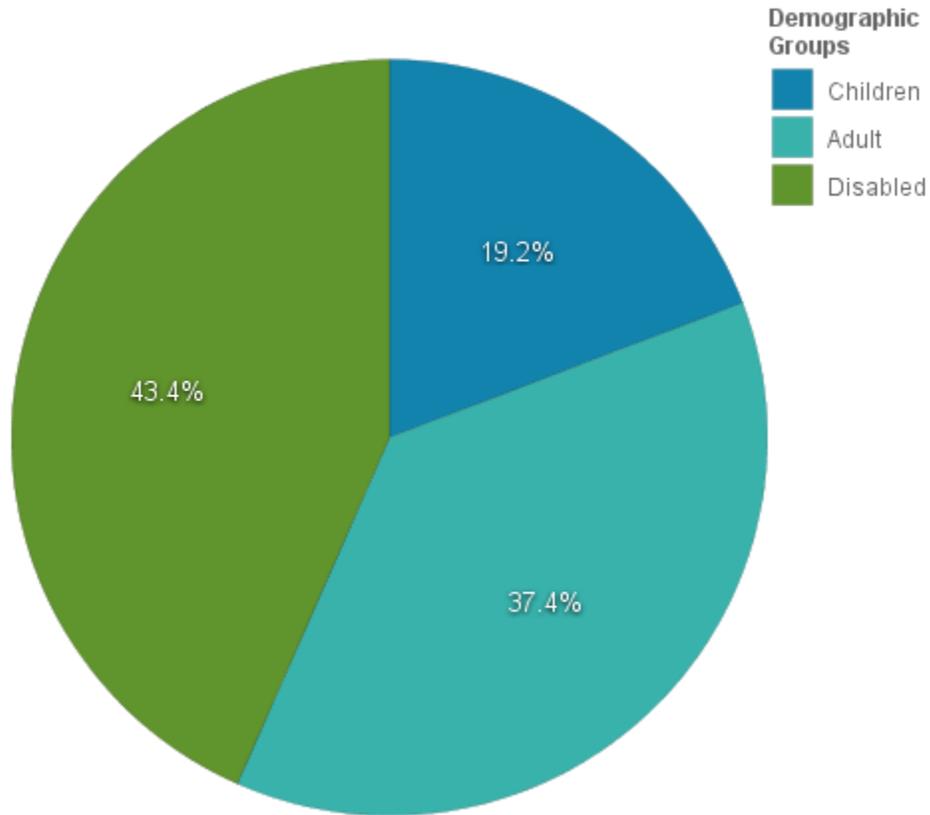


Figure 157 - Home Health Services utilizers by demographic group

Analysis of Demographic Groups:

Individuals with disabilities and adults make up the majority of the utilizers of this service.

Figure 158 is a FY 2014-15 snapshot of gender groups by utilizer count. This shows the gender distribution of service utilizers. *Fulfills requirement 42 CFR 447.203(b)(1)(iv)*

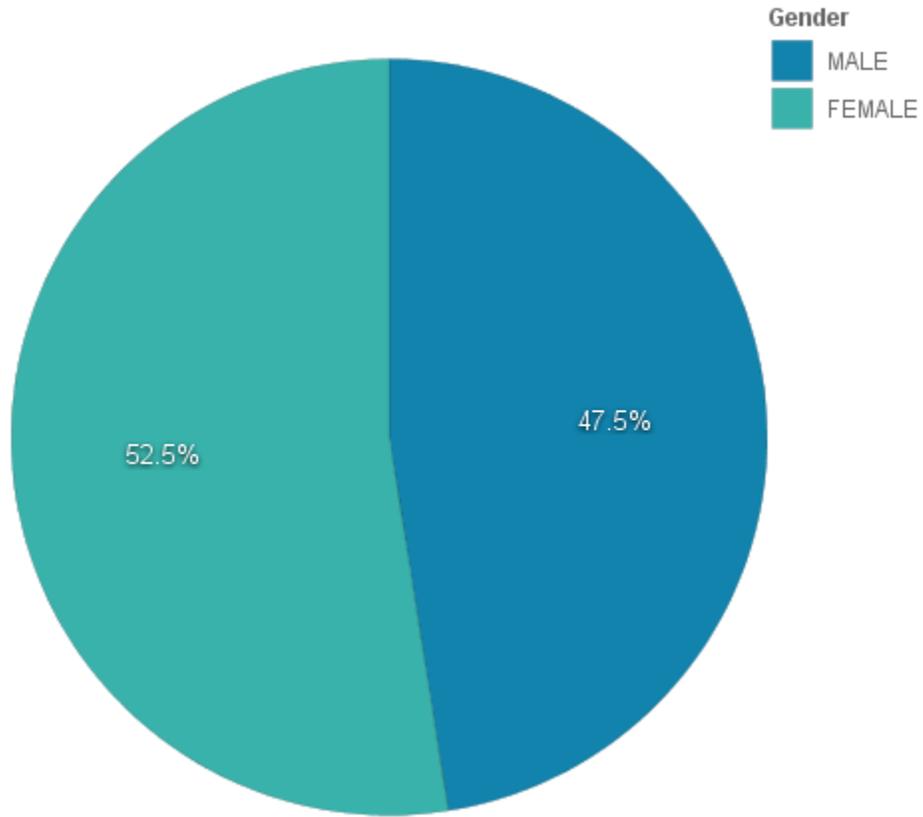


Figure 158 - Home Health Services utilizers by gender

Analysis of Gender Groups:

While the majority of utilizers are male, the gender distribution is relatively even.

Figure 159 is a FY 2014-15 snapshot of age groups by utilizer count. This depicts the age distribution of service utilizers. *Fulfills requirement 42 CFR 447.203(b)(1)(iv)*

Home Health Utilizer Age Groups

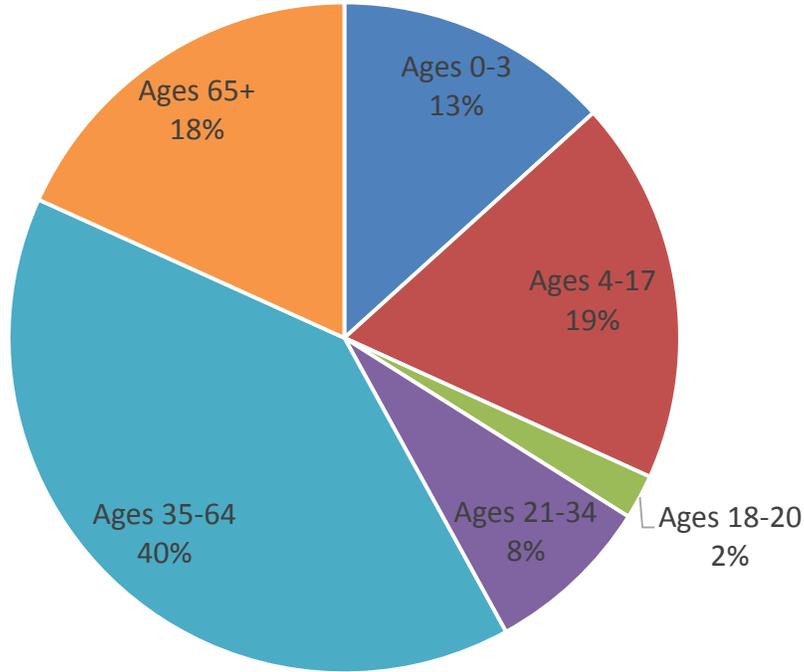


Figure 159 - Home Health Services utilizers by age groups

Analysis of Demographic Groups:

Approximately half of utilizers were between the ages of 21 to 64.

Table 12 is a FY 2014-15 snapshot of top 10 diagnoses by utilizer count, further broken out by demographic group. It includes what percentage of total service utilizers each demographic group constituted. This characterizes the needs of the beneficiary population. *Fulfills requirement 42 CFR 447.203(b)(1)(iv)*

Top 10 Root Diagnosis Codes		
Rank: 1 Principal Diagnosis 315		
Code Description SPECIFIC DELAYS IN DEVELOPMENT		
Total Members: 1,939		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	Blinded	Blinded
Children	1,497	77.2%
Individuals with Disabilities	Blinded	Blinded
Rank: 2 Principal Diagnosis V57		
Code Description CARE INVOLVING USE OF REHABILITAION PROCEDURES		

Total Members: 1,486		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	712	47.9%
Children	223	15.0%
Individuals with Disabilities	551	37.1%
Rank: 3 Principal Diagnosis 250		
Code Description DIABETES MELLITUS		
Total Members: 1,384		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	753	54.4%
Children	Blinded	Blinded
Individuals with Disabilities	Blinded	Blinded
Rank: 4 Principal Diagnosis V58		
Code Description OTHER & UNSPEC PROCEDURES AND AFTERCARE		
Total Members: 1,043		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	655	62.8%
Children	40	3.8%
Individuals with Disabilities	348	33.4%
Rank: 5 Principal Diagnosis 343		
Code Description INFANTILE CEREBRAL PALSY		
Total Members: 920		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	32	3.5%
Children	120	13.0%
Individuals with Disabilities	768	83.5%
Rank: 6 Principal Diagnosis V54		
Code Description OTHER ORTHOPEDIC AFTERCARE		
Total Members: 712		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	552	73.3%
Children	Blinded	Blinded
Individuals with Disabilities	Blinded	Blinded
Rank: 7 Principal Diagnosis 299		
Code Description PERVASIVE DEVELOPMENTAL DISORDERS		
Total Members: 554		
Demographic Groups	Utilizer Count	Percent by Demographic Group

Adults	Blinded	Blinded
Children	Blinded	Blinded
Individuals with Disabilities	419	75.6%
Rank: 8 Principal Diagnosis 780		
Code Description GENERAL SYMPTOMS		
Total Members: 493		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	285	57.8%
Children	Blinded	Blinded
Individuals with Disabilities	Blinded	Blinded
Rank: 9 Principal Diagnosis 758		
Code Description CHROMOSOMAL ANOMALIES		
Total Members: 472		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	Blinded	Blinded
Children	Blinded	Blinded
Individuals with Disabilities	373	79.0%
Rank: 10 Principal Diagnosis 783		
Code Description SYMPTOMS CONCERNING NUTRITION, METABOLISM, AND DEVELOPMENT		
Total Members: 466		
Demographic Groups	Utilizer Count	Percent by Demographic Group
Adults	Blinded	Blinded
Children	278	59.7%
Individuals with Disabilities	Blinded	Blinded

Table 12 - Home Health Services top 10 diagnosis codes by utilizer count

Analysis of Top 10 Diagnoses:

The top diagnoses are as expected. Many items were ‘blinded’ due to HIPAA requirements. These diagnoses indicate that utilizers of this service have developmental delays and physical conditions that require both acute and long-term care. This service is correctly targeting members with these conditions. As the top diagnoses are consistent with expectations, these statistics do not indicate an access issue, but cannot be interpreted in isolation.

Home Health Services Utilization Analysis by Geographic Region

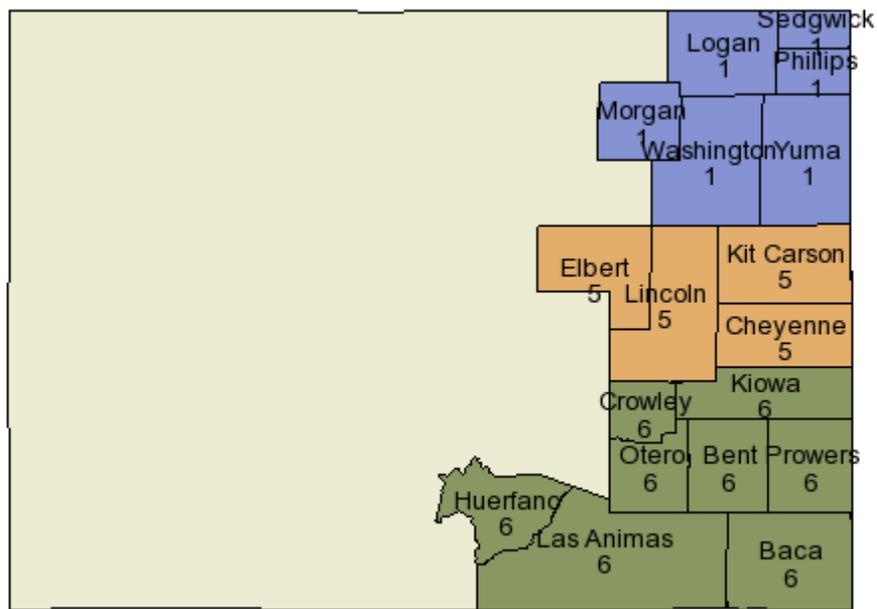
To best review access to health care services for Health First Colorado members, through the lense of administrative claims utilization data, the Department plotted three sets of data points stratified by each HSR. These were the total volume utilizer count, the active billing provider count, and the service

penetration rate.³⁴ What follows is a graphical examination of 18 month trends for each of seven groupings of HSRs. Only the utilization of members for whom Health First Colorado was the payer are shown.

HSRs 01, 05, and 06

Health Statistic Regions 01, 05, and 06 are comprised of residents from the eastern part of the State. These three regions reported approximately 152,000 insured persons in 2013, and grew to approximately 172,000 insured persons by 2015.

Predominately rural, these HSRs account for approximately 3.1% of the State's overall population.



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Figure 160 - Diagram of HSRs 01, 05, 06

³⁴ If Medicaid members utilized other services that were paid for by their private insurance or Medicare, that utilization is not captured here.

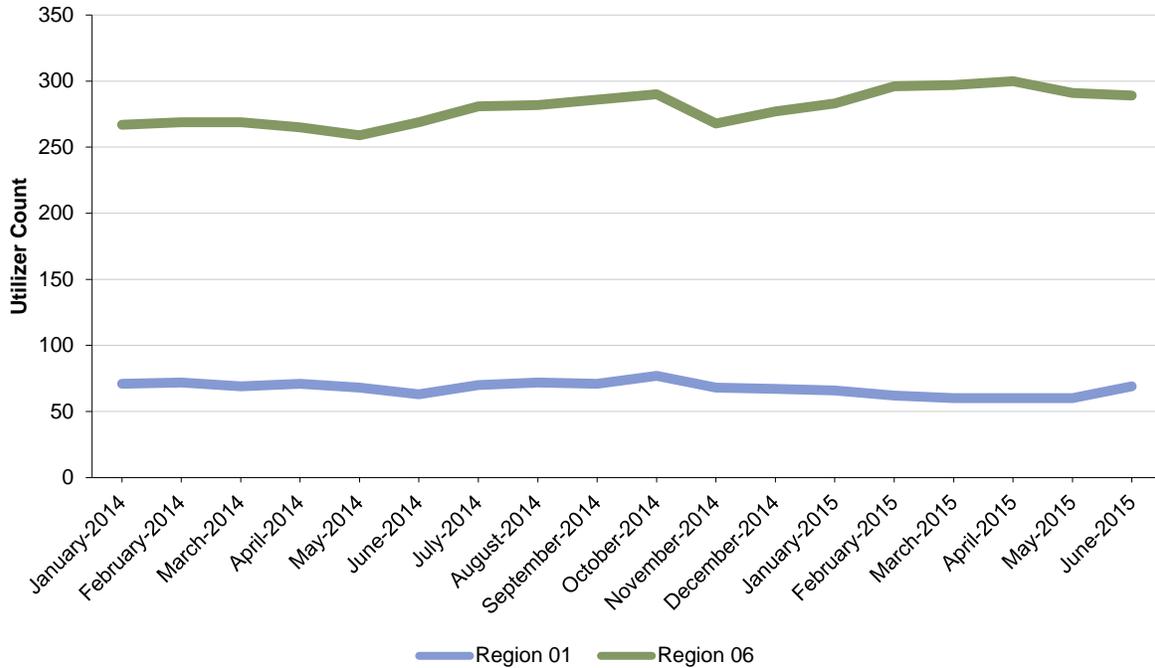


Figure 161 - Home Health Services utilizer count, HSRs 01, 06

The utilizer counts in these regions appear relatively stable year-over-year with Region 06 reporting higher numbers of utilizers than Region 01. This aligns with CHAS data, which reports HSR 06 having approximately 30% more members than that of Region 01. HSR 05 has such few utilizers that the data has been blinded per HIPAA requirements.

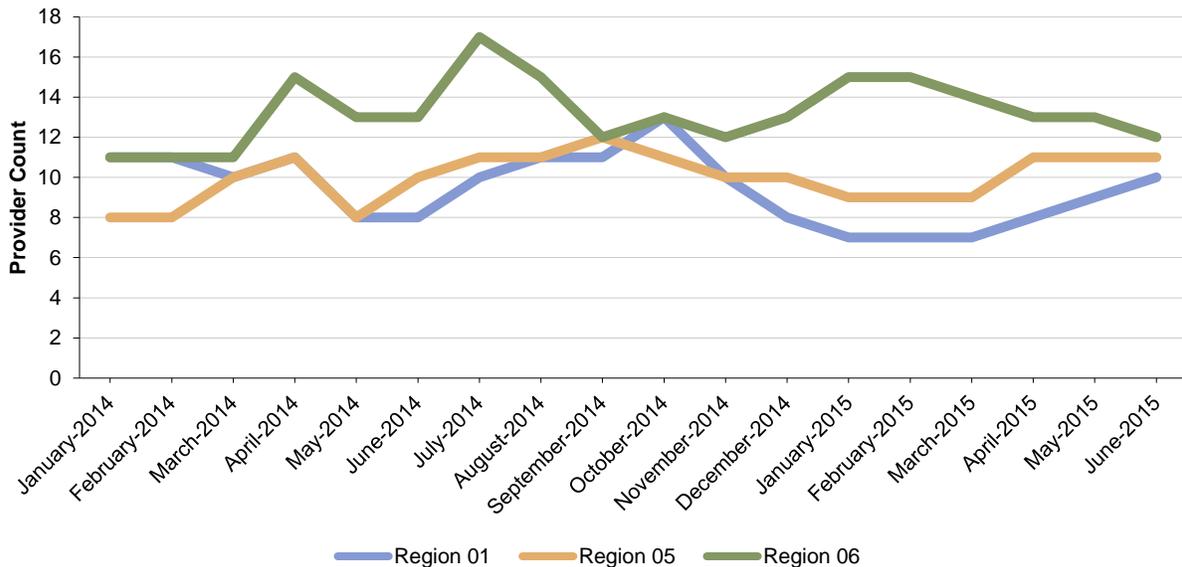


Figure 162 - Home Health Services provider count, HSRs 01, 05, 06

Regions 01, 05 and 06 experience periodic fluctuations in their provider count trends. However year-over-year, it appears that the provider count remains relatively stable as a whole.

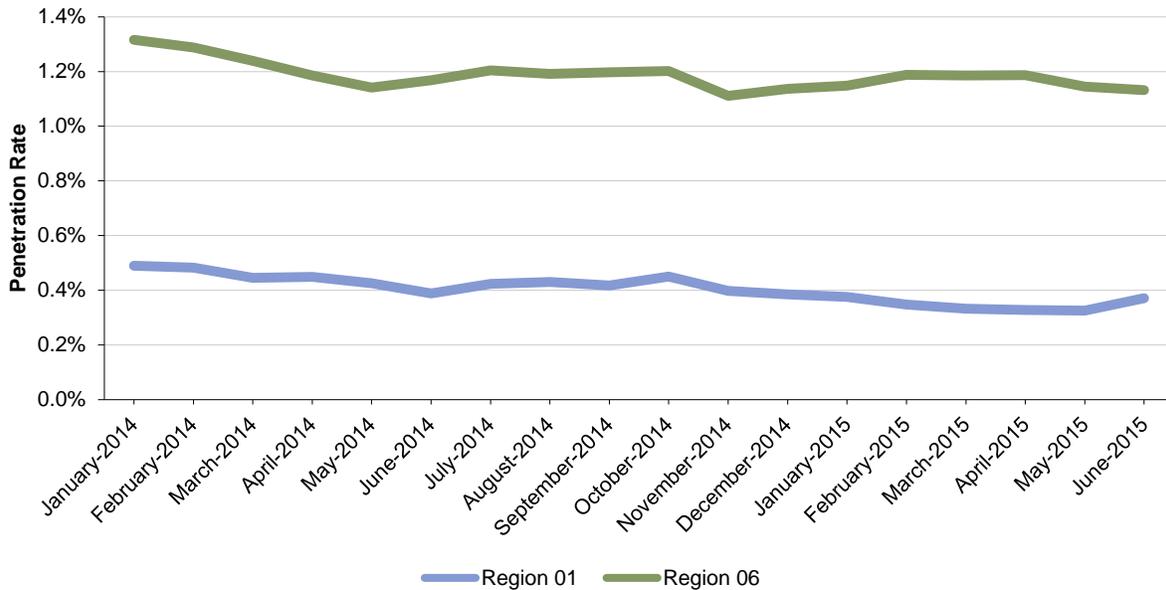


Figure 163 - Home Health Services penetration rate, HSRs 01, 06

While the penetration rates for Regions 01 and 06 trended slightly downward as of May 2014, a similar shift was apparent in May 2015. This suggests that such fluctuation may be normal and the overall trend is relatively stable. HSR 05 has such few utilizers that the data has been blinded per HIPPA standards.

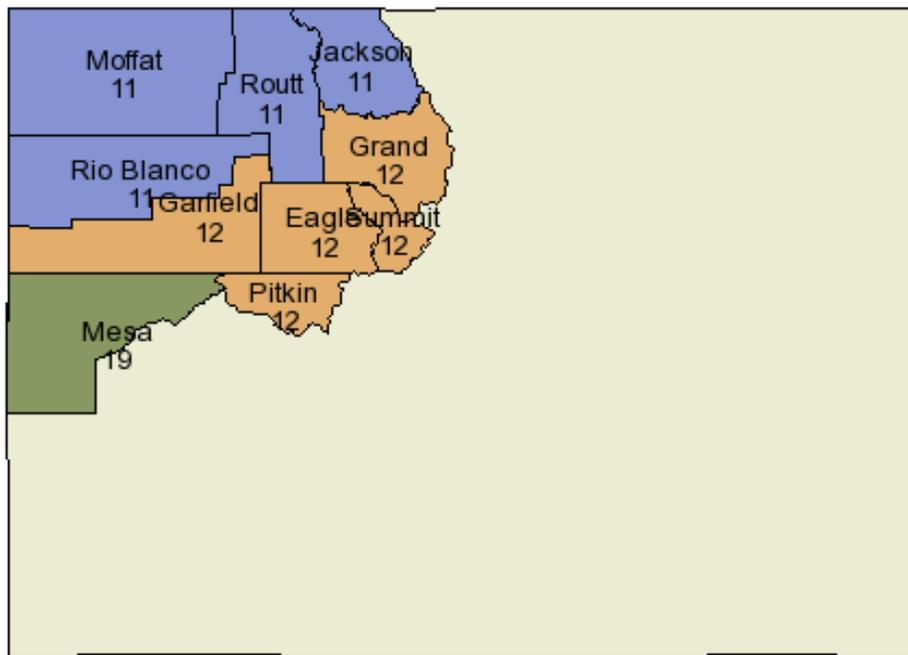
Analysis for HSRs 01, 05, and 06

Viewed together with the periodic shifts in provider count, there is no access issue identified in these HSRs.

HSRs 11, 12, and 19

Health Statistic Regions 11, 12, and 19 are comprised of residents from the north-western part of the State. These three regions reported approximately 297,000 insured persons in 2013, and grew to approximately 321,000 insured persons by 2015.

Predominately rural and mountainous, with one major urban center, these HSRs account for approximately 5.8% of the State's overall population.



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Figure 164 - Diagram of HSRs 11, 12, 19

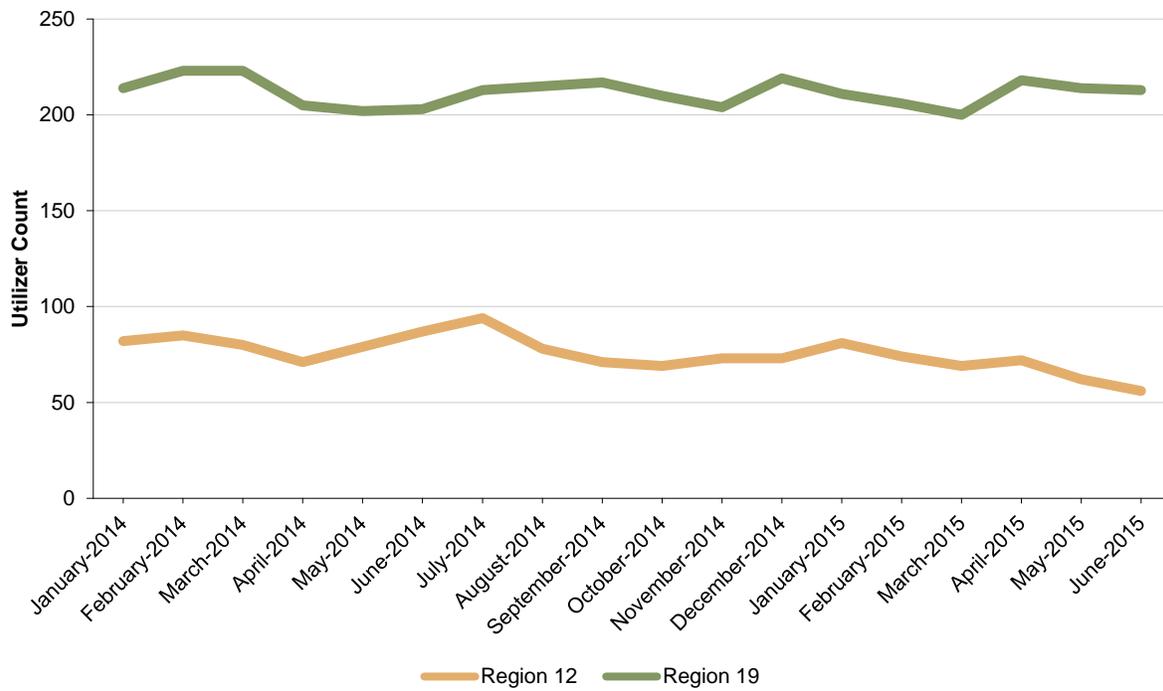


Figure 165 - Home Health Services utilizer count, HSRs 12, 19

The utilizer counts for these regions appear relatively stable year-over-year, with Region 19 reporting higher utilizer numbers than Region 12. This aligns with CHAS data, which reports Region 19 as having approximately 10% more overall insured persons than Region 12. HSR 11 has such few utilizers that the data has been blinded per HIPPA requirements.

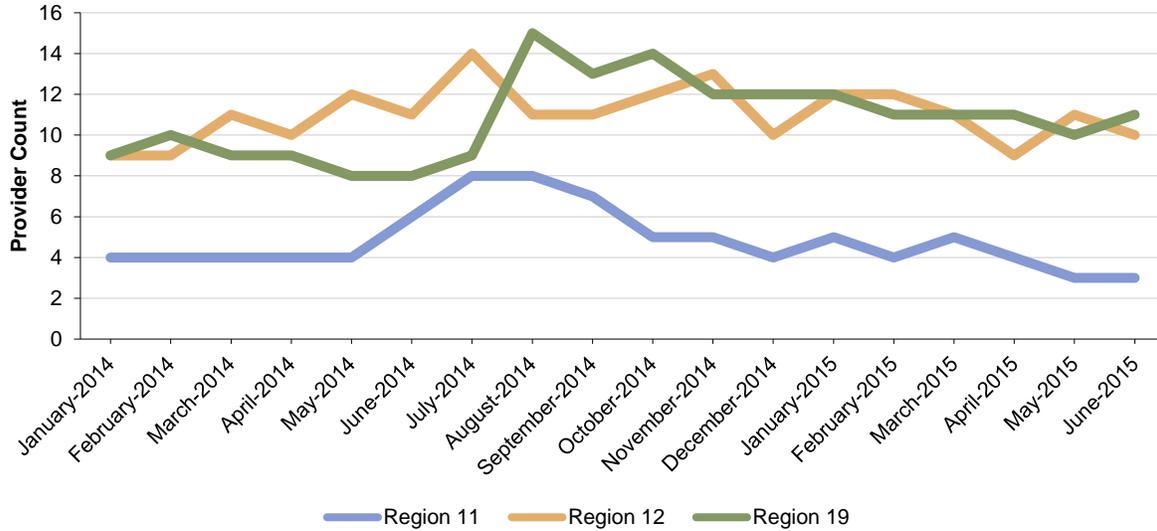


Figure 166 - Home Health Services provider count, HSRs 11, 12, 19

The provider counts in these regions fluctuated from month to month, with spikes in July to November of 2014. They appear to have leveled out beginning in January 2015, and remained relatively stable through June 2015. Again, due to the small population of Medicaid members in Region 11, provider rates were much higher in Regions 12 and 19 as compared to Region 11.

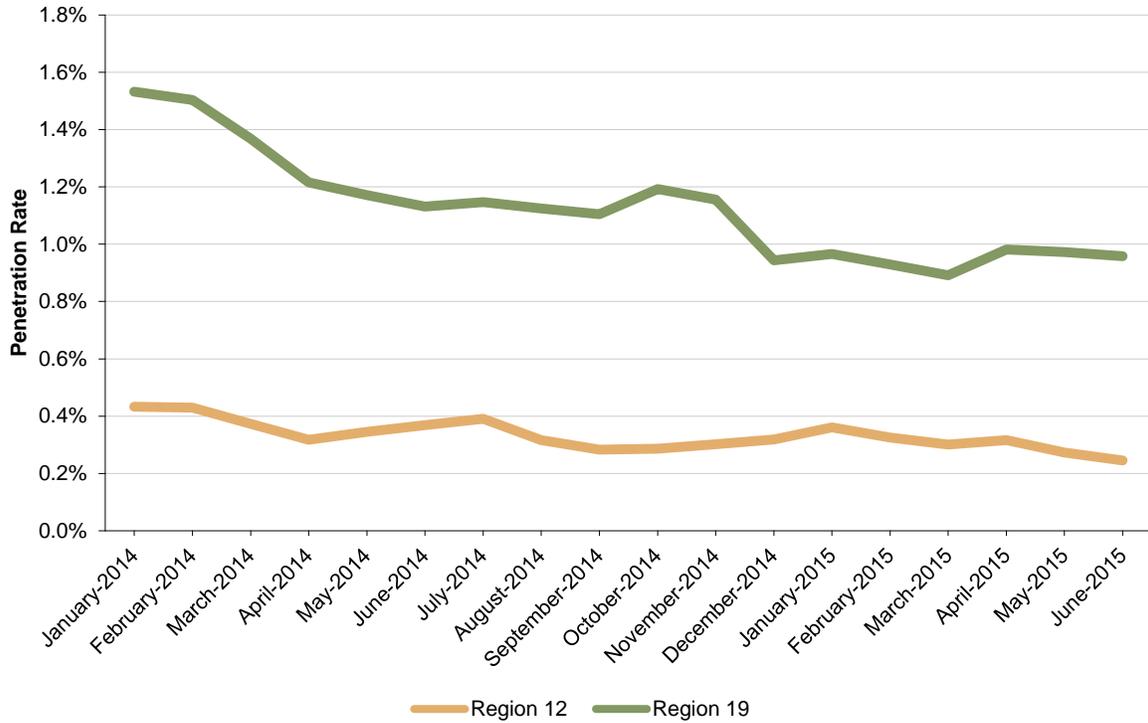


Figure 167 - Home Health Services penetration rate, HSRs 12, 19

Penetration rates for Regions 12 and 19 appear relatively stable, with mild decreases from January 2014 to July 2015. HSR 11 has such few utilizers that the data has been blinded per HIPPA standards.

Analysis for HSRs 11, 12, and 19

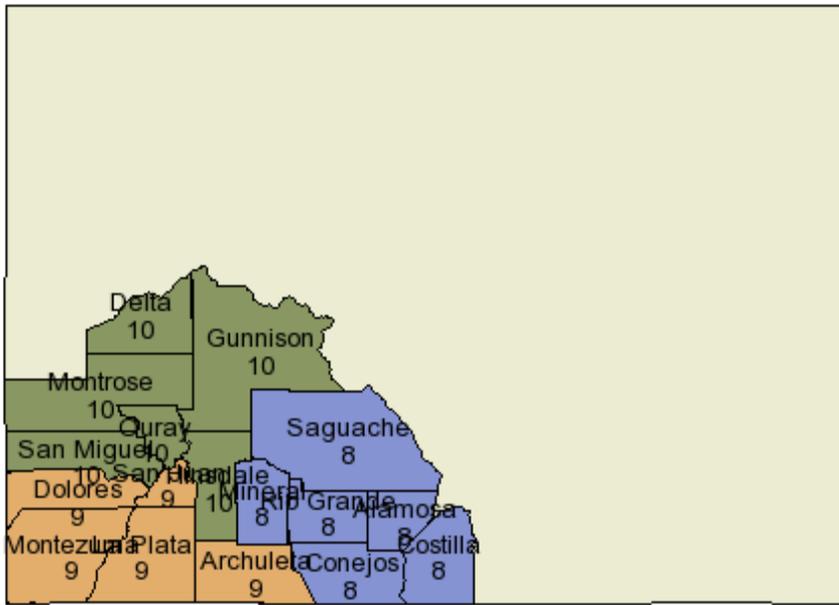
HSRs 12 and 19 showed stable trends in utilization. Each region experienced a provider count spike in the summer of 2014, but stabilized by the summer of 2015. Both HSR 12 and 19 also showed stable benefit penetration rates.

Based on these data sets, these statistics do not appear to indicate an access issue.

HSRs 08, 09, and 10

Health Statistic Regions 08, 09, and 10 are comprised of residents from the south-western part of the State. These three regions reported approximately 196,000 insured persons in 2013, and grew to approximately 199,000 insured persons by 2015.

Predominately rural and mountainous, these HSRs account for approximately 3.6% of the State's overall population.



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Figure 168 - Diagram of HSRs 08, 09, 10

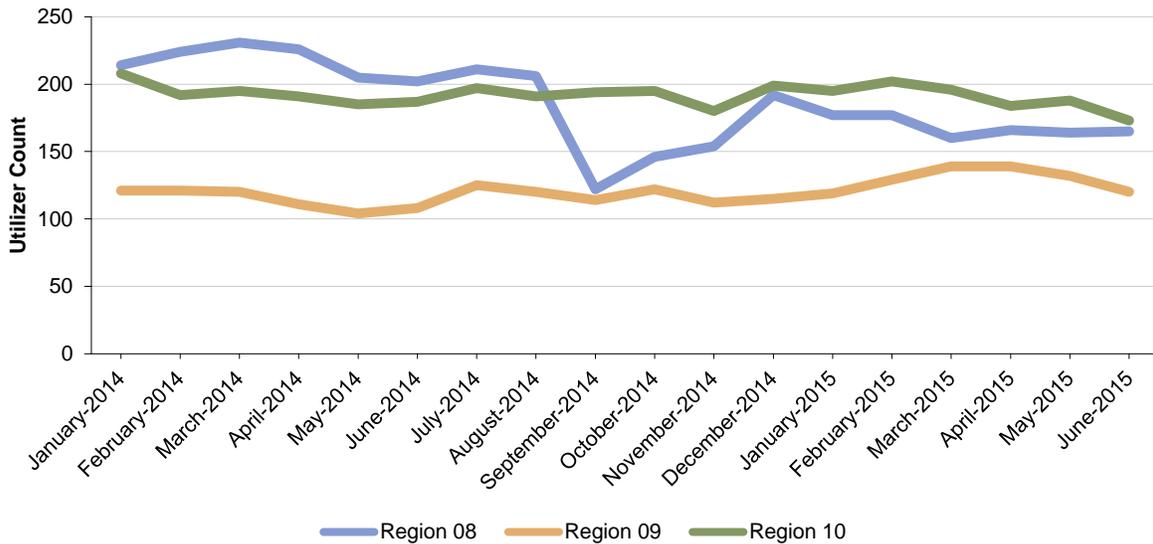


Figure 169 - Home Health Services utilizer count, HSRs 08, 09, 10

The utilizer counts for Regions 09 and 10 remained relatively stable year-over-year, with no concerning fluctuations from January 2014 to July 2015. The utilizer count for Region 08 remained relatively stable until August 2014, when the utilizer count appears to experience a moderate decline. In December 2014 it appears to have returned to higher levels and continued at that rate through July 2015.

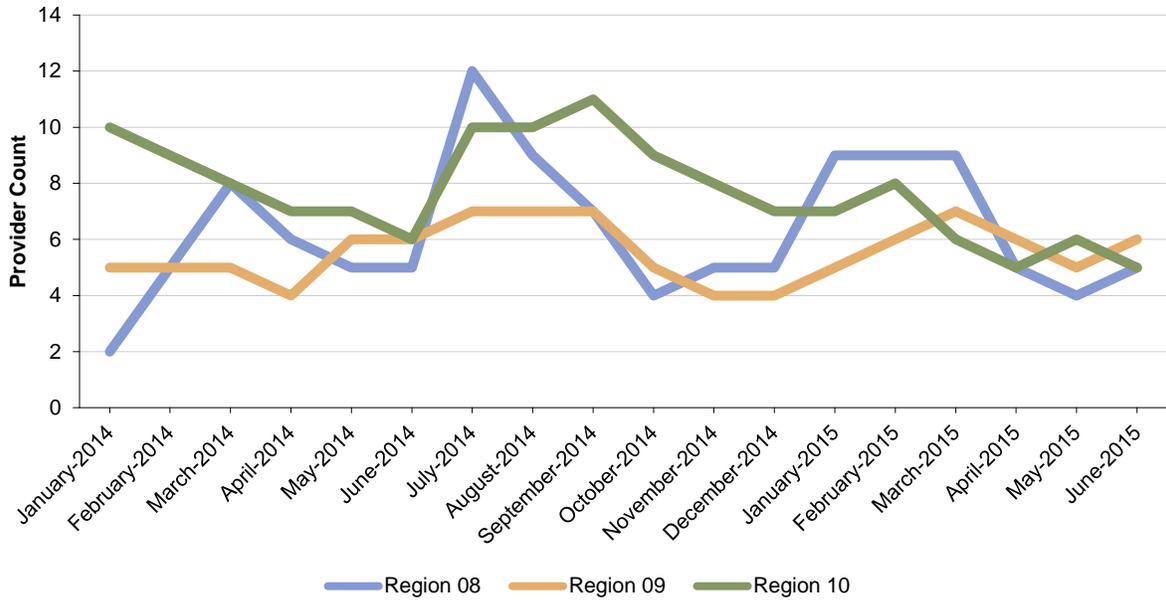


Figure 170 - Home Health Services provider count, HSRs 08, 09, 10

In general, there appears to have been a slight decline in provider count from January 2014 to June 2015.

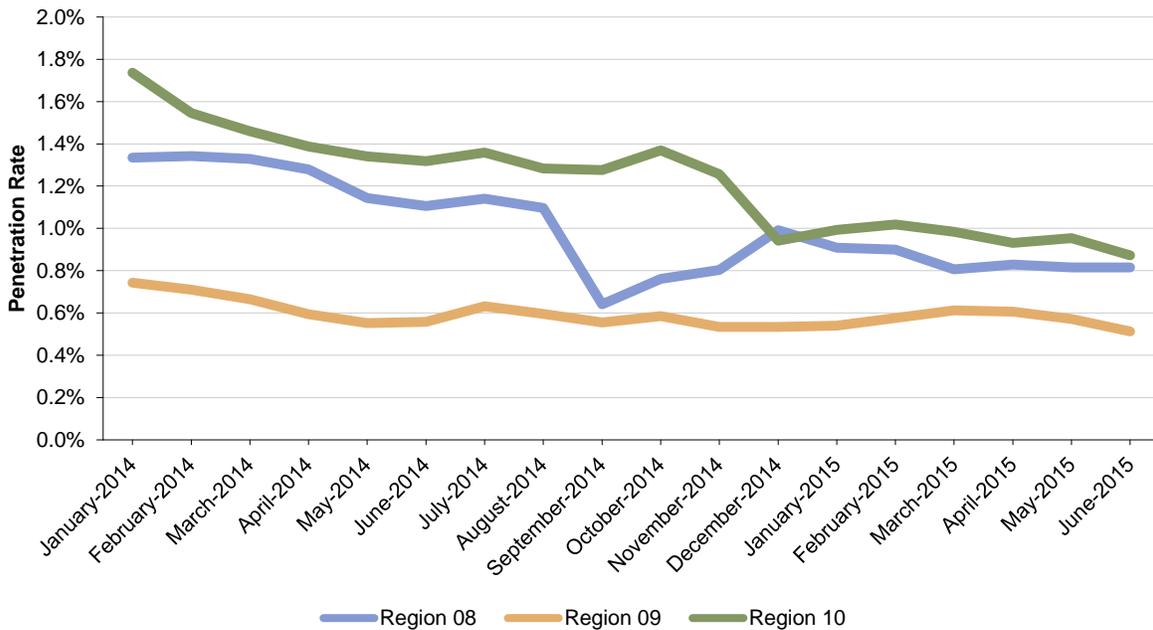


Figure 171 - Home Health Services penetration rate, HSRs 08, 09, 10

Penetration rates appear to have declined from January 2014 to July 2015. The sharp decline may be attributed to an increase in adult members through Medicaid expansion, who do not require Home Health Services, which has the effect of diluting the total count of members and reducing the penetration rate.

Analysis for HSRs 08, 09, and 10

HSR 08 showed a sharp decrease in utilizers in August 2014, which stabilized in March 2015. An analogous trend is apparent in the penetration rate for HSR 08. This does not indicate an access issue because the active provider count increased.

Penetration rates were stable for all three HSRs as of December 2014 onward, with only a small decrease in HSR 09. Both HSR 09 and 10 showed stable benefit penetration rates.

These statistics do not indicate an access issue.

HSRs 04, 07, and 13

Health Statistic Regions 04, 07, and 13 are comprised of residents in the central to southern part of the State. These three regions reported approximately 750,000 insured persons in 2013, and grew to approximately 800,000 insured persons by 2015.

A mix of urban and rural with some mountainous regions, these HSRs account for approximately 14.6% of the State's overall population.



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Figure 172 - Diagram of HSRs 04, 07, 13

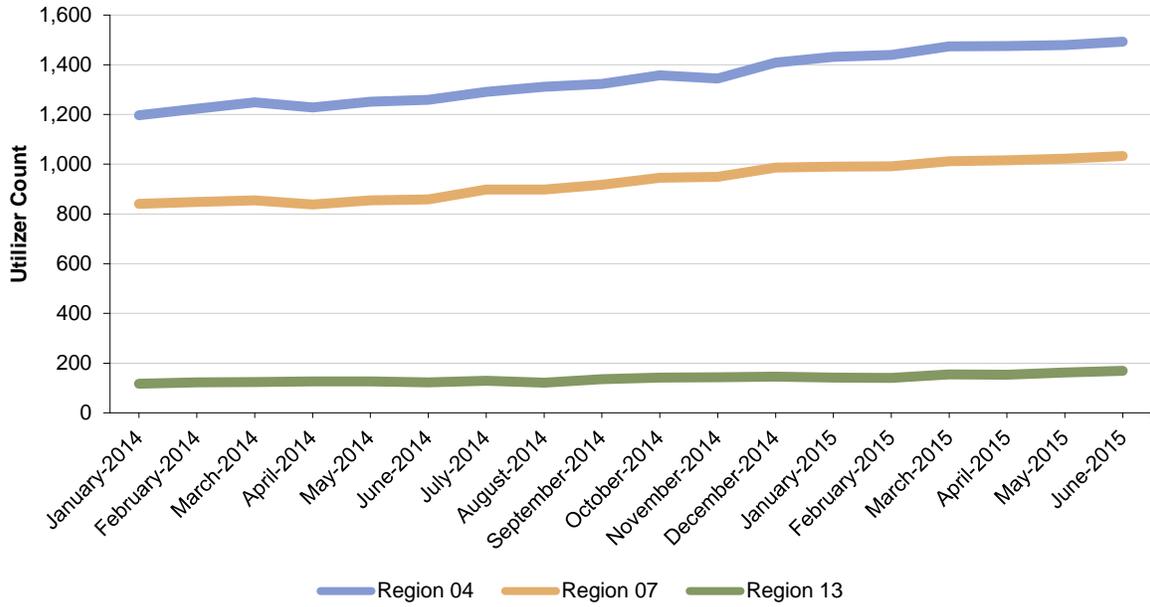


Figure 173 - Home Health Services utilizer count, HSRs 04, 07, 13

The utilizer counts for these regions remained stable, with a slight increase in utilizer count from January 2014 to July 2015.

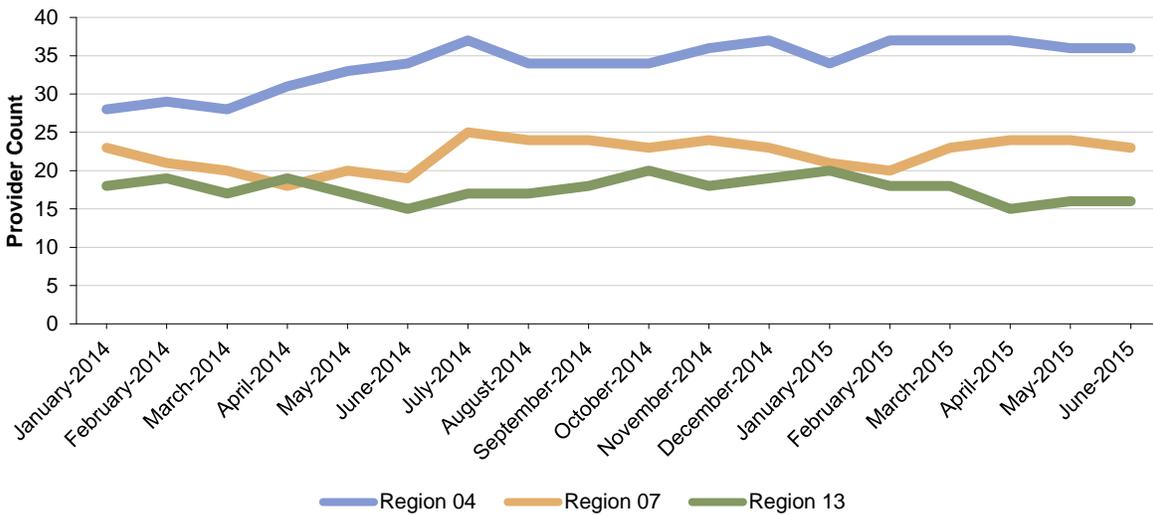


Figure 174 - Home Health Services provider count, HSRs 04, 07, 13

The provider counts appear stable year-over-year. Region 04 had a larger provider count than Regions 07 and 13. This aligns with CHAS data which estimates Region 04 having more than six times the amount of insured persons than Regions 07 and 13.

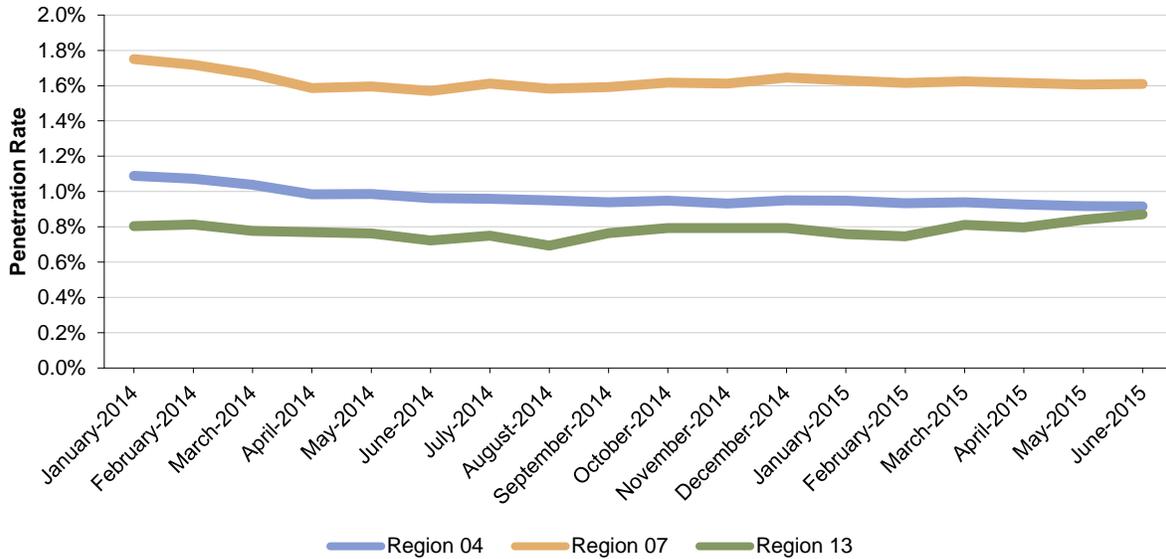


Figure 175 - Home Health Services penetration rate, HSRs 04, 07, 13

Penetration rates for these regions all remained relatively stable during the 18 month observation period.

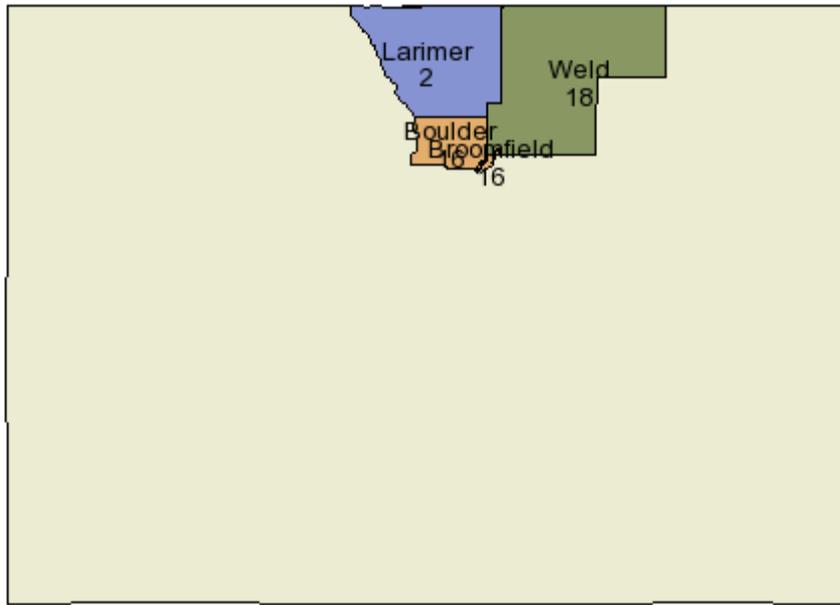
Analysis for HSRs 04, 07, and 13

HSR 04, 07 and 13 showed a slight and consistent increase in utilizer count and stable penetration rates. Active provider counts for HSRs 07 and 13 remained stable, while the active provider count for HSR 04 increased slightly. These statistics do not indicate an access issue.

HSRs 02, 16, and 18

Health Statistic Regions 02, 16, and 18 are comprised of residents in the central and northern part of the State. These three regions reported approximately 770,000 insured persons in 2013, and grew to approximately 825,000 insured persons by 2015.

Predominately rural and somewhat mountainous, with numerous urban centers, these HSRs account for approximately 15.1% of the State's overall population.



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Figure 176 - Diagram of HSRs 02, 16, 18

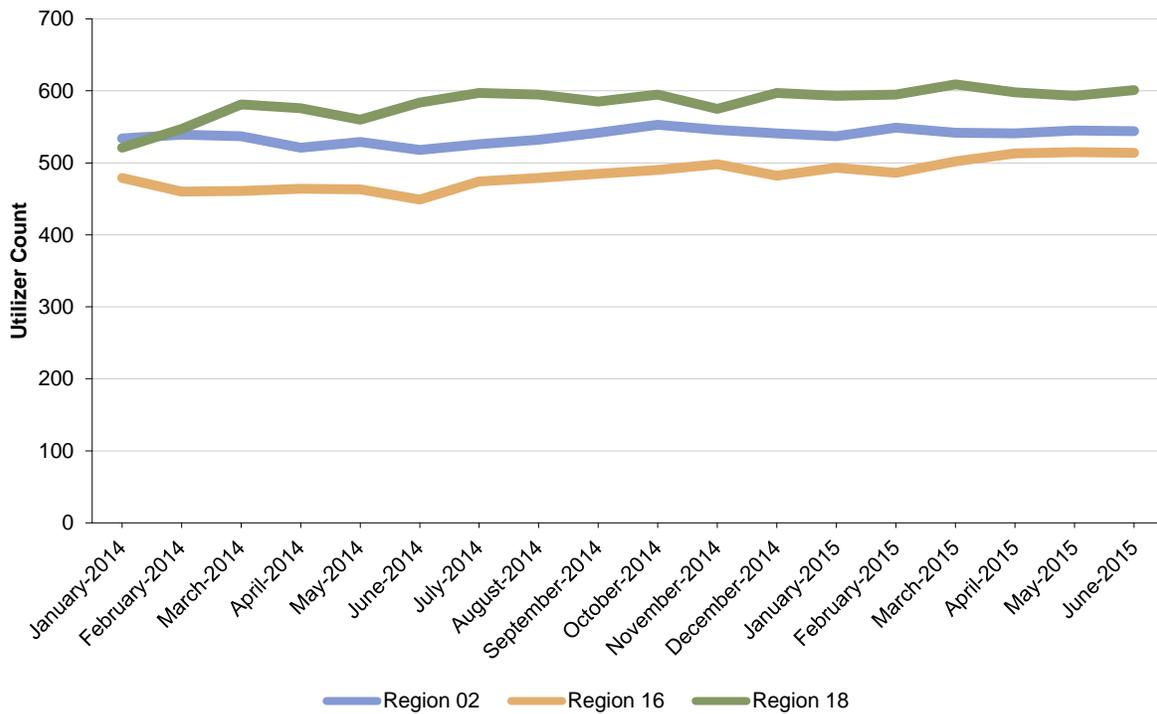


Figure 177 - Home Health Services utilizer count, HSRs 02, 16, 18

The utilizer counts for these regions remained relatively stable from month to month, with a slight increase from January 2014 to July 2015.

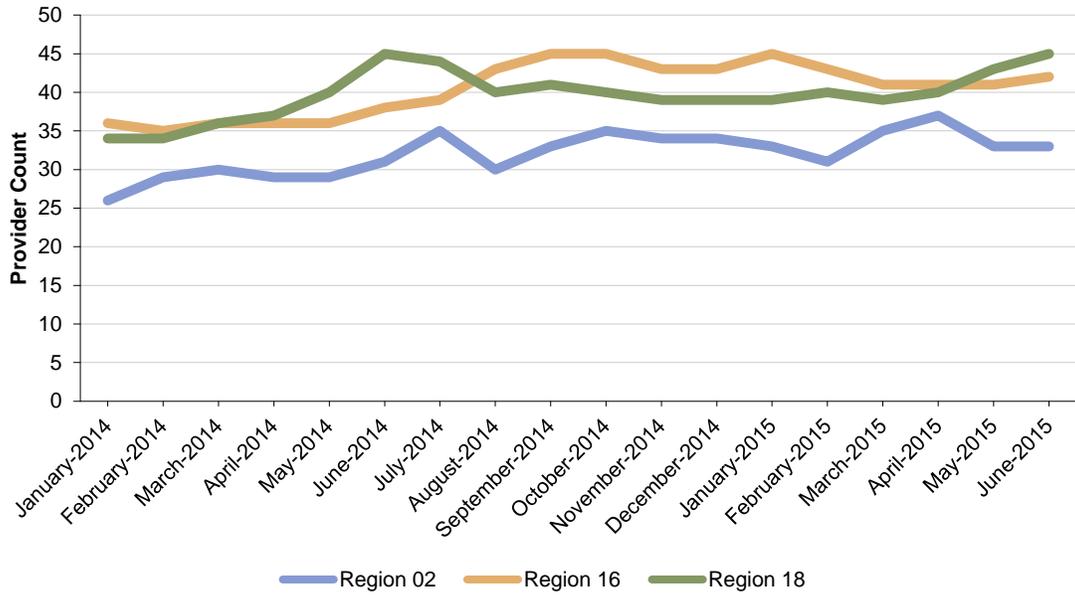


Figure 178 - Home Health Services provider count, HSRs 02, 16, 18

Similar to utilizer count, the provider counts appear stable month to month, with a slight increase from January 2014 to July 2015.

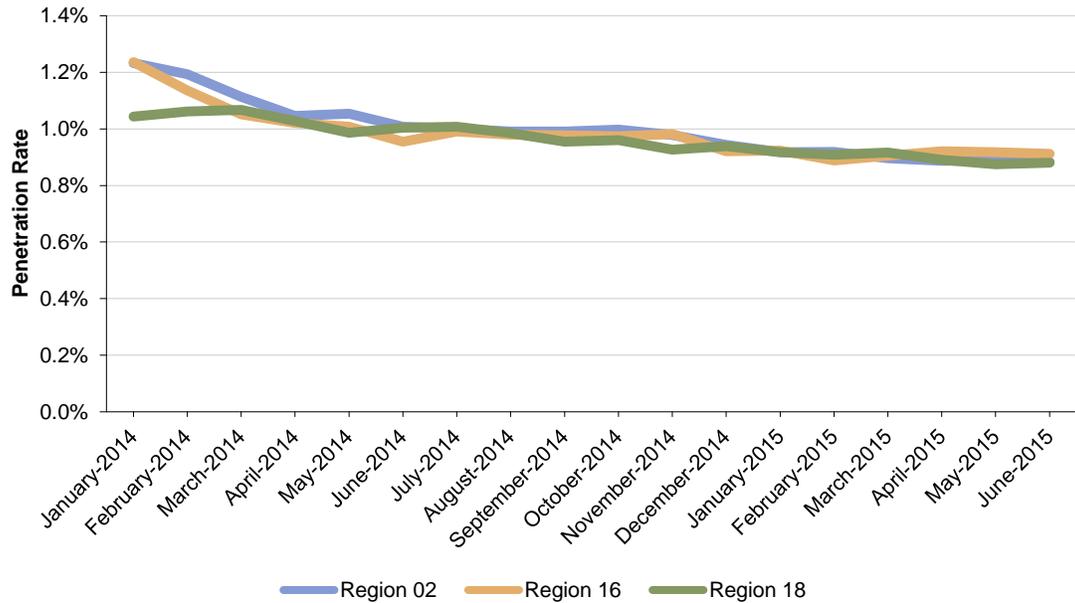


Figure 179 - Home Health Services penetration rate, HSRs 02, 16, 18

These regions showed stable benefit penetration rates. The decrease year-over-year, despite increases in the provider count, is likely due to Medicaid expansion; few expansion adults utilize Home Health Services.

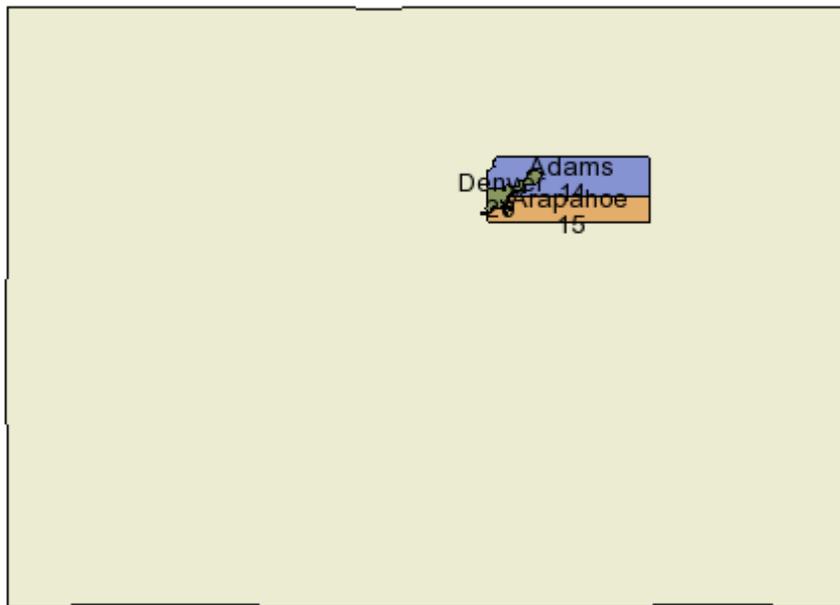
Analysis for HSRs 02, 16, and 18

HSR 02, 16 and 18 each demonstrated a stable upward trend in utilizer count. The active provider count for each HSR correspondingly increased over the past 18 months. These statistics do not indicate an access issue.

HSRs 14, 15, and 20

Health Statistic Regions 14, 15, and 20 are comprised of residents in the central part of the State. These three regions reported approximately 1,333,000 insured persons in 2013, and grew to approximately 1,377,000 insured persons by 2015.

Predominately urban, geographically, these HSRs account for approximately 25.2% of the State's overall population.



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Figure 180 - Diagram of HSRs 14, 15, 20

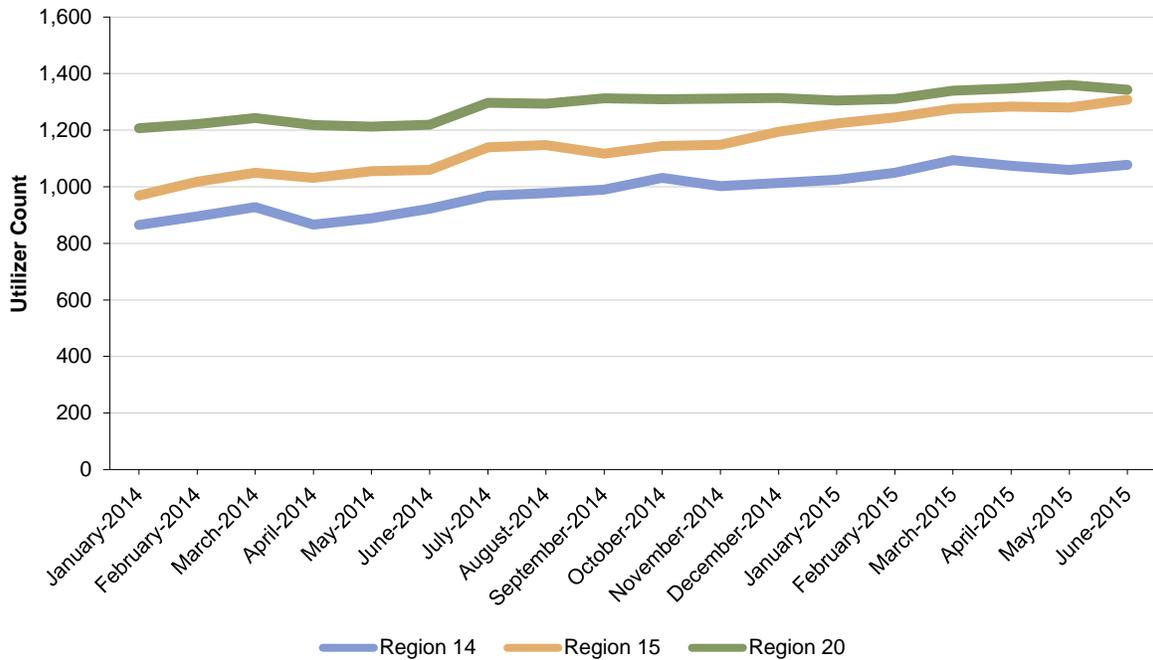


Figure 181 - Home Health Services utilizer count, HSRs 14, 15, 20

The utilizer counts for these regions remained relatively stable month over month, with a slight increase from January 2014 to July 2015. Region 20 appears to have had a higher utilizer count. This aligns with CHAS data, which showed that the utilizer count for Medicaid members in Region 20 was 23% larger than Region 15, and 32% larger than Region 14.

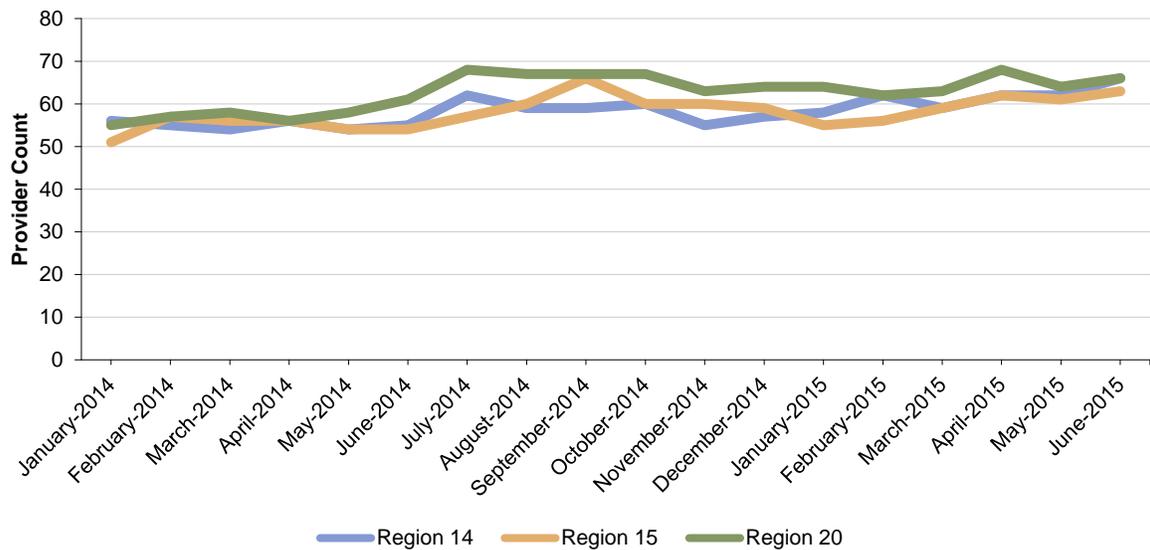


Figure 182 - Home Health Services provider count, HSRs 14, 15, 20

The provider counts appear stable in these regions, with a slight increase in providers from January 2014 to July 2015.

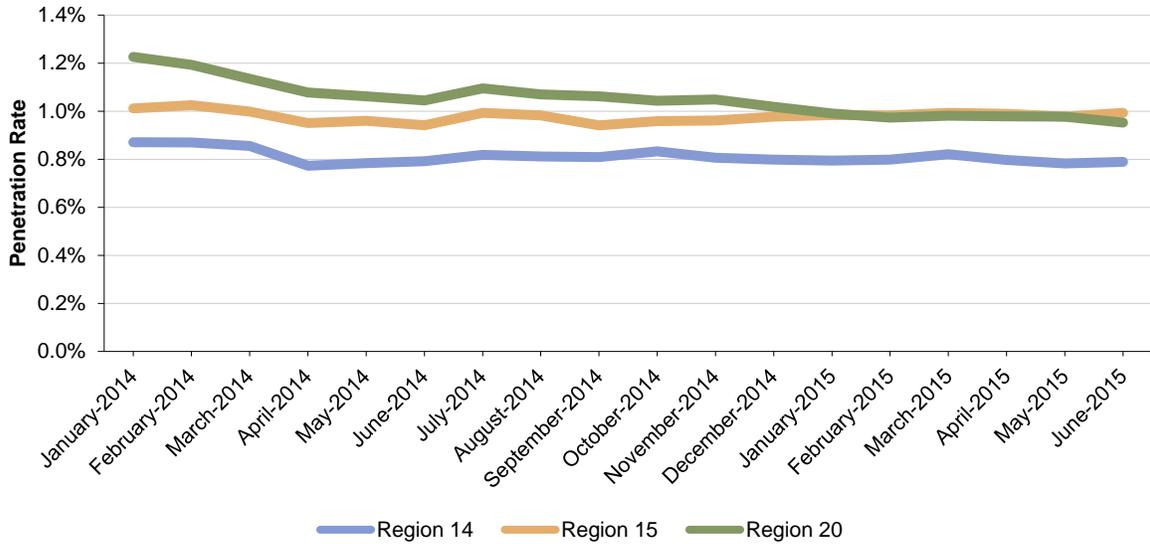


Figure 183 - Home Health Services penetration rate, HSRs 14, 15, 20

It appears that there was a slight decrease in utilization from January 2014 to July 2015, however the decline is minimal.

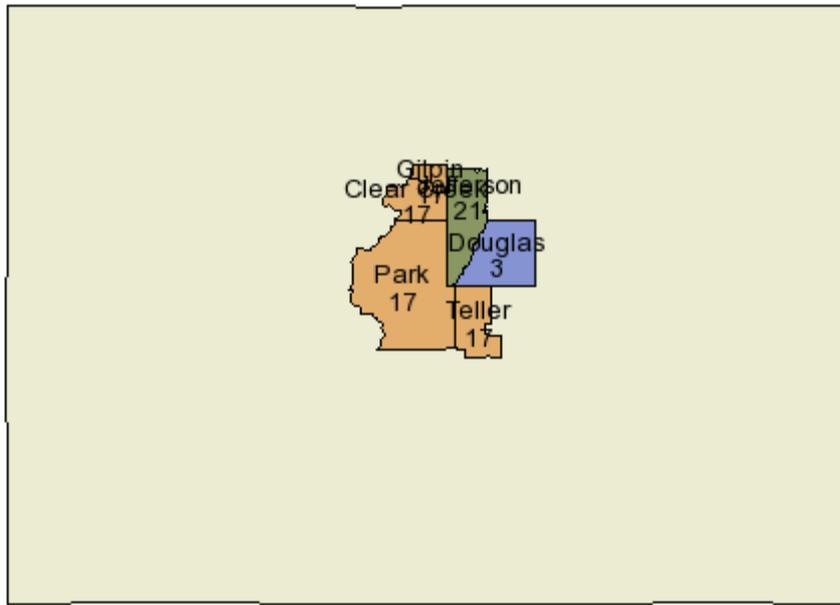
Analysis for HSRs 14, 15, and 20

HSRs 14, 15 and 20 showed a steady increase in utilizer counts from January 2014 through June 2015. Active provider counts for each HSR also slightly increased during that time. The penetration rates for HSRs 14, 15 and 20 decreased marginally beginning in January 2014, but stabilized in April 2014. These statistics do not indicate an access issue.

HSRs 03, 17, and 21

Health Statistic Regions 03, 17, and 21 are comprised of residents in the central part of the State. These three regions reported approximately 79,000 insured persons in 2013, and grew to approximately 876,000 insured persons by 2015.

A mix of urban and rural geography, these HSRs account for approximately 16% of the State's overall population.



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Figure 184 - Diagram of HSRs 03, 17, 21

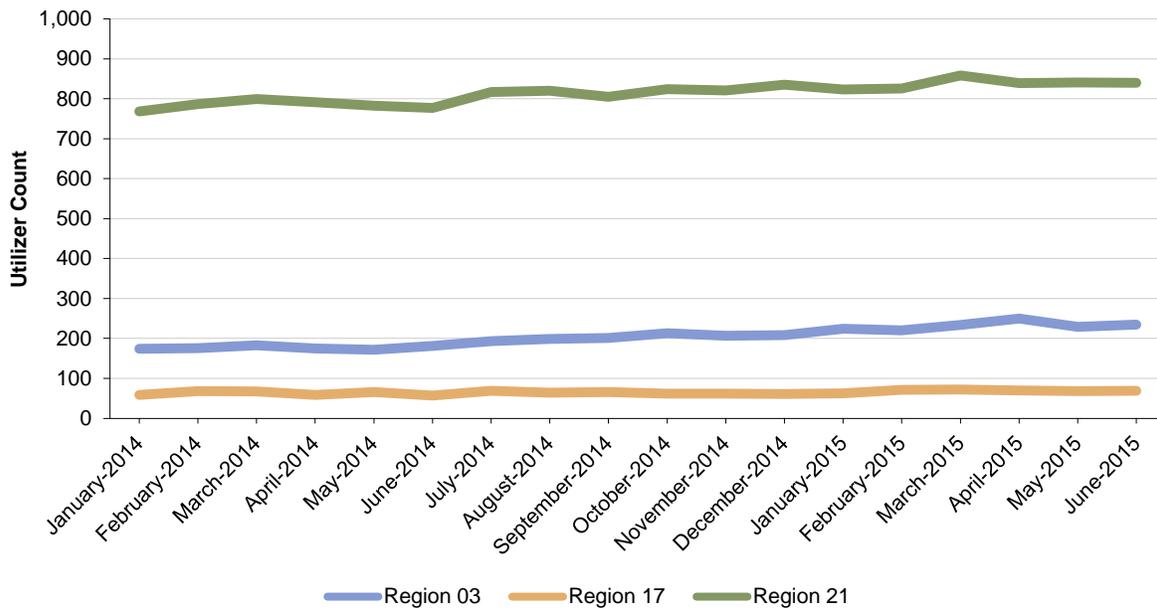


Figure 185 - Home Health Services utilizer count, HSRs 03, 17, 21

The utilizer counts for these regions remained relatively stable from January 2014 to July 2015. This aligns with CHAS data, which reports Region 21 as having approximately two times the payer population of Region 03, and nine times that of Region 17.

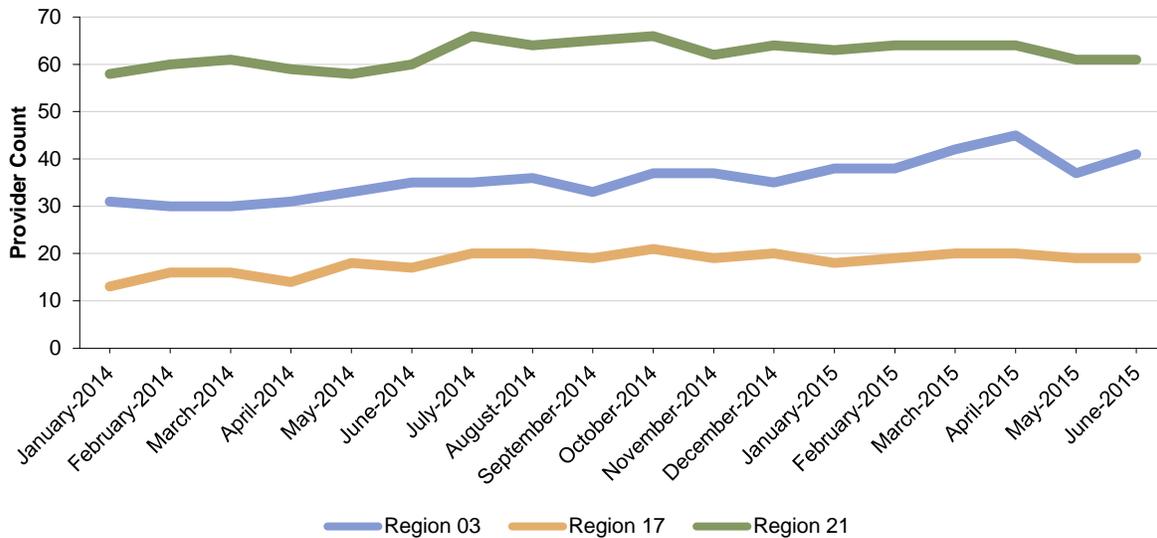


Figure 186 - Home Health Services provider count, HSRs 03, 17, 21

Similarly, provider counts for these regions appear stable month over month, with Region 21 reporting higher counts of providers than Regions 03 and 17.

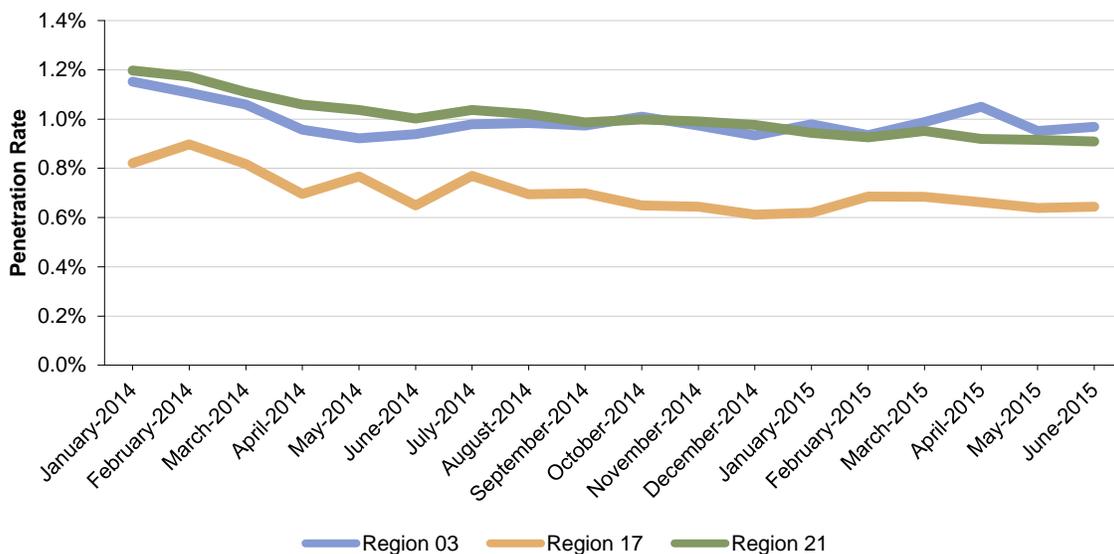


Figure 187 - Home Health Services penetration rate, HSRs 03, 17, 21

Penetration rates for these regions appear stable from January 2014 to July 2015, with a slight decrease year-over-year. Region 17 reported the lowest level of utilization, which appears to align with the proportion of utilizers and providers for that region.

Analysis for HSRs 03, 17, and 21

HSRs 14, 15 and 21 showed stable and slightly increasing trends in utilizer counts from January 2014 through June 2015. Active provider counts for each HSR has also increased steadily, with HSR 3 demonstrating a spike between February 2015 and April 2015. The penetration rates for each HSR

decreased beginning in January 2014 before stabilizing in July 2014. These statistics do not indicate an access issue.

Home Health Services Analysis by Provider Type and Place of Service

Figures 188 and 189 are FY 2014-15 snapshots of Billing Provider type by utilizer count. They depicts the distribution of billing provider types within the service category who deliver the benefit. *Fulfills requirement 42 CFR 447.203(b)(1)(ii)*

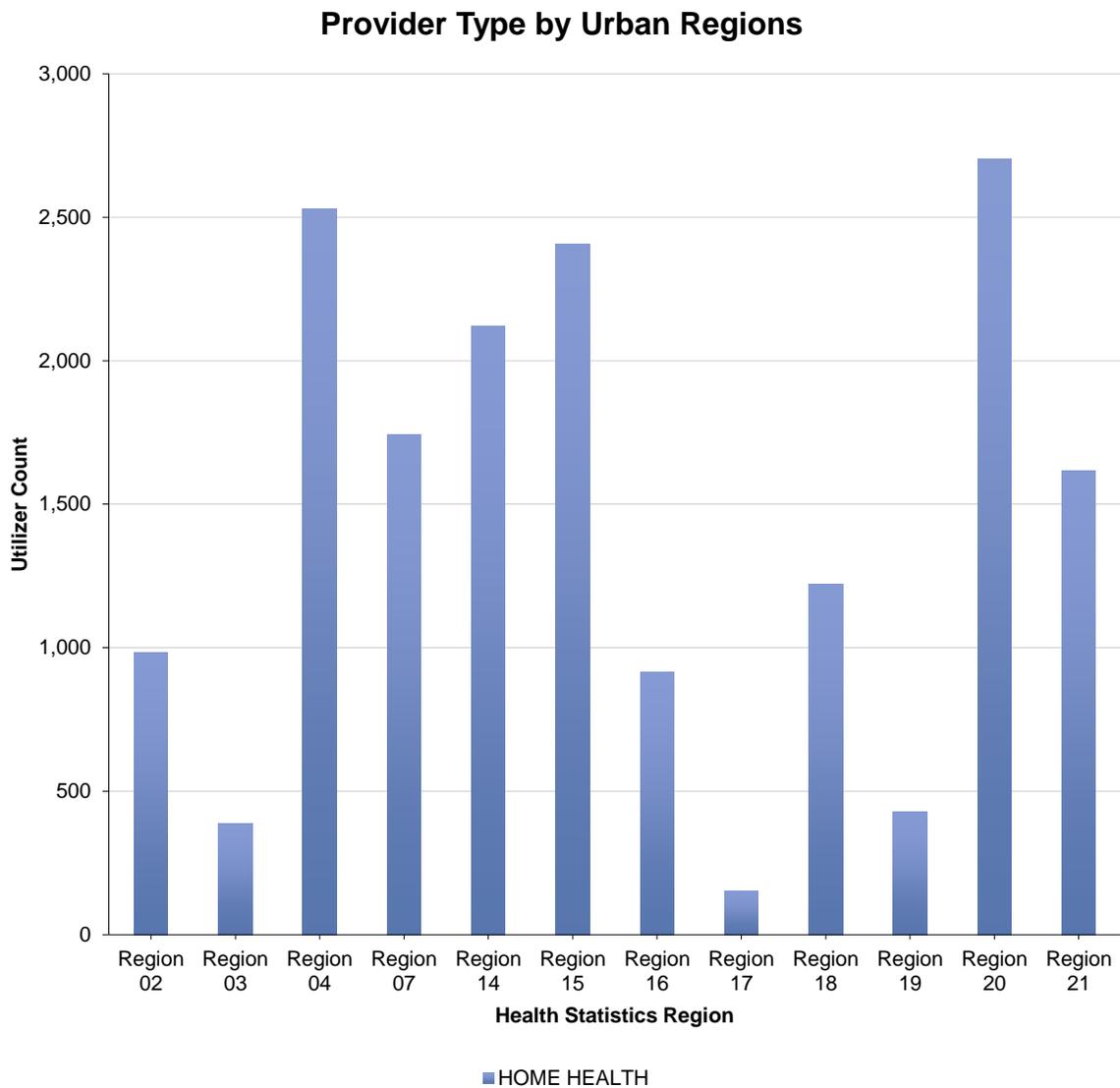


Figure 188 - Home Health Services provider type by urban HSRs

Provider Type by Rural Regions

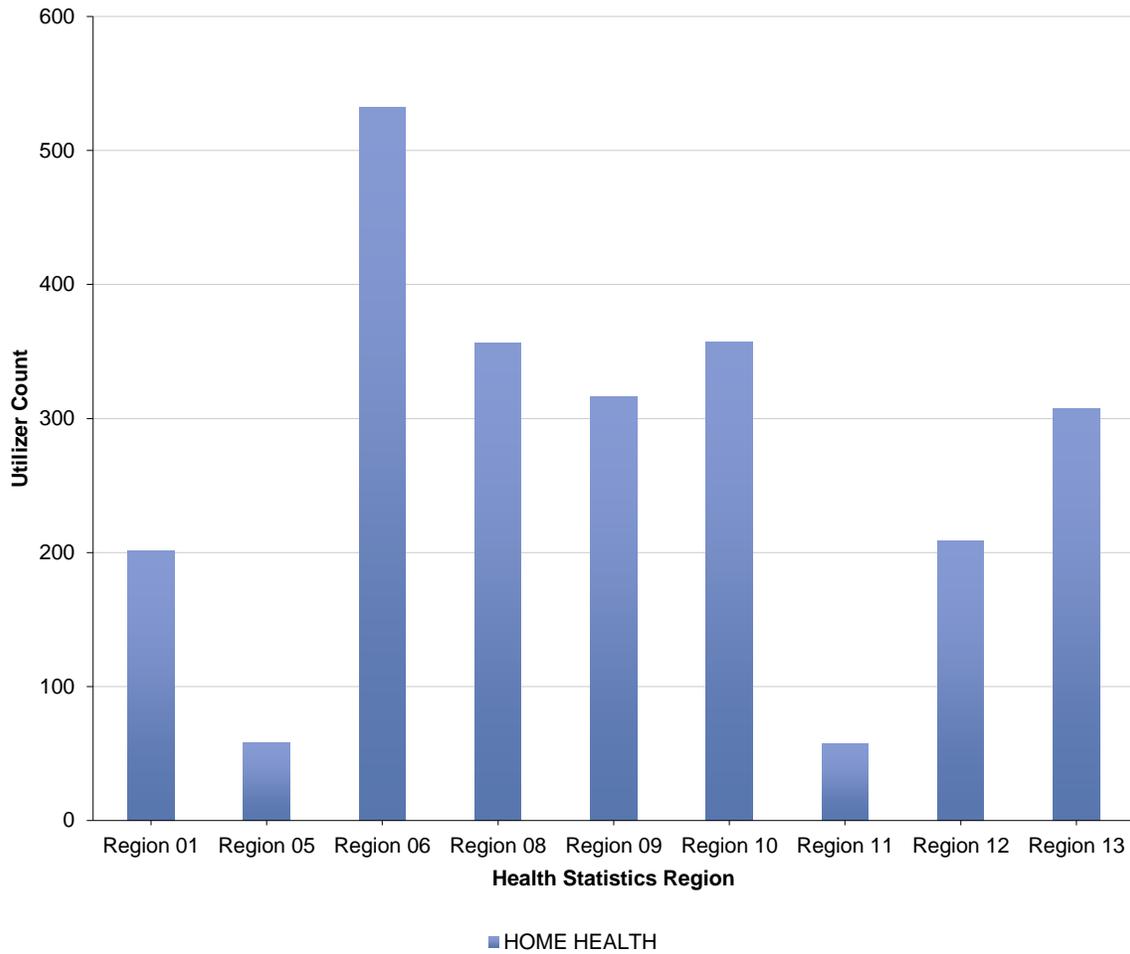


Figure 189 - Home Health Services provider type by rural HSRs

Analysis of Provider Type

The benefit is delivered by licensed and certified class A Home Health agencies across HSRs, consistent with the needs of Home Health Services. As Home Health Services are delivered in the member's place of residence, there is no variance in the distribution of place of service within this service category. Utilizers of this benefit access Home Health Services in their place of residence throughout the State's rural and urban areas and no access issue has been identified.

Home Health Services Colorado Health Access Survey Data

No 2015 CHAS data pertinent to this service was available

Home Health Services Rate Comparison – Actual or Estimated Levels of Provider Payment

Fulfills requirement 42 CFR 447.203(b)(1)(v)

In aggregate, the 2016 Health First Colorado rates for Home Health Services are 24.29% higher than the average 2014 CIVHC (Colorado All Payer Claims Database) rate. Medicare rates were not available for comparisons due to complicated differences in coding between the two systems which could not be reconciled to provide meaningful analysis.

Home Health Services Input from Beneficiaries, Providers, and Stakeholders

Fulfills requirement 42 CFR 447.204(a)(2)

Fulfills requirement 42 CFR 447.204(b)(3) – as applicable under ‘Specific Analysis of Input from Stakeholders Affected by a Payment Restructure or Reduction’

Home Health Services Direct-to-Staff Input

Department staff occasionally receive unsolicited input directly from beneficiaries, providers, and stakeholders concerning access to care for this service while performing their operational duties. Staff address and catalogue those access comments in accordance with the procedures detailed in the Access Monitoring Review Plan – Appendix A.

From January 2014 to June 2015 we received five comments of this kind concerning access to care. Three comments were from members inquiring about where to find a provider. These were addressed by directing the member to the ‘find a provider’ tool on website and by referral to their case manager, when applicable. Two provider comments were received regarding access to care in a rural county due to a Home Health agency closure. Department staff worked with the Colorado Department of Public Health and Environment and the closing agency to successfully transfer all members to surrounding Home Health agencies.

Home Health Targeted Stakeholder Input and Input from General Public Notice

A draft of this Plan was sent to key stakeholders and was made publically available on the Department’s website for 30 day public comment. Feedback and input was accepted through email and through an online survey and is summarized in Appendix K. Several stakeholders pointed to anomalies in the way the data and analysis above was originally presented. Where applicable, the Department has clarified within the body of the Plan.

One stakeholder group asserted that many individuals with disabilities continue to experience difficulty in securing Home Health Services, such as 24 hour backup, care at odd hours, care 365 days a year, and providers equipped to work with difficult members. The Department acknowledges the difficulties individuals can face when accessing their health care benefits; and believe this issue is not unique to individuals with disabilities. Every effort is made to ensure the Medicaid program is as accessible as possible for every member, while being especially cognizant of members with disabilities.

Home Health Services Access Issues Discovered As a Result of This Review

Fulfills requirements 42 CFR 447.203(b)(4)

This is a list of the Access Issues identified using the data available in this review. Data which suggests an Access Issue will be investigated and monitored for a period of two consecutive quarters to ensure the pattern is not an artifact or data anomaly. If investigation does reveal a deficit, the Access Issue becomes an Access Deficiency which triggers the process described in the Access Monitoring Review Plan – Appendix B (42 CFR 447.203(b)(8)).

No access issues were identified as a result of this analysis.

Home Health Services Extent to Which Beneficiary Needs Are Fully Met

Fulfills requirements 42 CFR 447.203(b)(1)(i)

The Home Health benefit covers a variety of skilled care services in both acute and long-term time frames. Access to care did not appear deficient for any of these services. The Home Health benefit remains a critical medical service and will continue to be monitored closely. Data showed that members receiving Home Health Services were able to access Home Health providers in rural and urban areas. Utilizer demographics did not indicate an access issue and penetration rates were shown to be sufficient across all HSRs. Colorado recognizes that Home Health Services are integral in allowing members to safely receive person-centered care in their homes and will continue to evaluate its utilization throughout the State.

The Department's analytical conclusion is that Home Health Services are sufficient to enlist enough providers so that services are available at least to the extent they are available to the general population in each geographic area, pursuant to section 1902(a)(30)(A) of the Social Security Act.

Appendix K: Targeted Stakeholder Input and Input from General Public Notice

Pursuant to federal regulation 42 CFR 447.203(b), this Access Monitoring Review Plan (Plan) was sent to key stakeholders and the Department’s medical advisory committee, and was made publically available on the Department’s website for 30 day public comment. The Department also sent notice to the State’s tribes. The public comment period opened on June 9, 2016 and closed on July 25, 2016. Feedback and input was accepted through email and through an online survey.

Feedback received pertained to both the analysis within, and the formatting of, the Plan, and is summarized below. The Department has also provided a response to these stakeholder considerations below.

Where applicable, the input received was used to inform both the final layout and formatting of the Plan and the final analysis of sufficiency of access to care for services under review.

Data Considerations

Stakeholders stated the following:

- 1. Comments: Access metrics do not capture certain key data points, such as the ratio of providers to enrollees, unmet referrals to specialty care or wait times to see a specialist.**

Response: The ratio of providers to enrollees does not reveal useful information pertaining to access but, rather, provider caseload. Some provider practices accept thousands of Medicaid members (such as Federally Qualified Health Centers), yet only count as one entity in such a ratio calculation. In this example, demand for services may be met, even though the ratio appears to indicate there may not be enough providers to meet member needs.

The Department does not have access to data that captures the rate of unmet referrals. This sort of information is not contained on an administrative claim. The same is true of wait times to see a specialist. Such information could be obtained through survey sampling, such as that conducted by the Colorado Health Access Survey, and can be explored further for the next iteration of the Access Monitoring Review Plan (Plan).

- 2. Comment: One stakeholder group strongly encouraged the Department to consider utilizing additional data points as listed in the final federal rule guidance document *Access Rule Implementation, Frequently Asked Questions, Item 12*, such as, but not limited to: time and distance standards, providers participating in the Medicaid program, providers with open panels, providers accepting new Medicaid beneficiaries, service utilization patterns, identified beneficiary needs, data on beneficiary and provider feedback and suggestion for improvement, the availability of telemedicine and telehealth, and other similar measures.**

Response: The Department considered the data points above and chose those for which data was available and valid for use in the Plan. For instance, the data point of “time and distance standards” was not chosen for this iteration of the Plan because:

- current Department data analytical capabilities are not sufficient to calculate this metric for such broad categories of service; and

- variable geography, especially in mountainous areas, causes the actual travel distance, from a member to a provider, to exceed the distance between the two ‘as the crow flies’. This distorts calculations and renders the data unusable.

As the Department continues to develop its analytical capabilities it will explore the possibility of using new data points to analyze access.

3. Comment: Exactly how is the penetration rate used as a "baseline" for measuring access sufficiency? And, specifically:

- Why is it not used as a source of comparison of access across and between regions, and/or a means of comparison with the penetration rates of other payers?**
- The Plan states the threshold for possible investigation of an access issue going forward is if a penetration rate drops below 75% of the current "baseline" rate. Does this mean there must be a further (future) reduction of more than 25% of the baseline number in order to trigger an access review?**

Response: A penetration rate trend line establishes the baseline rate at which beneficiaries typically utilize a service.

Comparable data describing the precise utilization trends of these five services, across HSRs and for this time period, was not available from commercial and other public insurers. Therefore, the service penetration rate for each HSR is not valid for comparison against other penetration rate trends of other HSRs. It is valid for comparison with itself, in future analyses. Reasons for why penetration rates vary across HSRs will require further investigation to fully understand.

The Department has clarified in the body of the Plan how the 75% threshold will be used in future analyses.

4. Comment: Given that this report will serve as a baseline for future reports, can longer historical trends be included?

Response: The Department does not believe that using data prior to January 2014 would be valid in assessing the sufficiency of access to care because enrollment for Medicaid Expansion members (in January 2014) dramatically changed utilization patterns of the population.

5. Comments: While the State is only required to demonstrate that Medicaid enrollees can access services at least to the same extent as the general population in the same geographic area, the current analysis framework overlooks regional access issues in circumstances where an entire Health Statistic Region has insufficient access to care. Including a statewide Medicaid average in the “utilization analysis by geographic region” sections of the report would help ensure overall regional access issues are identified.

Response: Including the statewide average trends alongside trends for each HSR would be insightful but is not required within this Plan. The purpose of the Plan is to assess the sufficiency of access to care by provider type and site of service compared with the general

population *within* the same geographic region, not to evaluate whether a particular region is below or above statewide trends.

6. **Comment: Can the Department include CHAS data on the percentage of individuals who “churn” on and off Medicaid coverage? Interruptions in coverage can compromise an individual’s continuity of care. Including data on churn in the current Plan, which serves as the baseline, will allow the Department to monitor spikes in churn in future Plans.**

Response: The Department does not have the data capabilities to reliably and accurately correlate how utilization patterns are affected by churn and how they relate to access to care. Therefore the statistics for ‘churn’ were not included in this version of the Plan. Once the Department has more robust data analytic capabilities, the Department will reconsider whether the metric of churn is appropriate to include in future versions of the Plan.

7. **Comments: This report states Medicaid enrollees were significantly more likely to go to an ER for a non-emergency than other insured Coloradans; why is this data not sufficient to indicate an access issue?**

Response: This metric could indicate an access issue but it could also reflect a member’s choice to visit an ER rather than another provider, or be attributed to the nature of the Medicaid member's health condition. For example, according to the 2015 Colorado Health Access Survey, Medicaid members were four times as likely to report their health as fair to poor than those with employer-sponsored or individual market insurance. This totals 25.9% of Medicaid members (compared with 6.1% to 11.0% of other insured persons). Since Medicaid members have poorer health, it is plausible that a portion of their ER use is attributable to those health conditions which become severe enough to seek immediate treatment despite access to other healthcare settings.

National data confirms the trend that Medicaid members utilize the ER at higher rates than other insured persons. Like other insured persons, Medicaid members report they would visit their primary care doctor instead of the ER if an appointment were immediately available, but this is often not the case across insurance types.

No one metric can be considered sufficient in and of itself to assess access. The Department’s conclusions about the sufficiency of access to care for each service are drawn from analysis of multiple metrics.

8. **Comments: Report lacks adequate data to compare Medicaid access to that of privately insured Coloradans. For example, the Department could compare Medicaid data with data found in the Colorado Division of Insurance’s network adequacy standards, including: total number of contracted providers; provider-to-enrollee ratios; volume of services available; appointment waiting times; and geographic access standards.**

Response: The Department looked into using data from the Colorado Division of Insurance and other sources, such as CIVIC, and determined that these sources were incomplete for the purpose of data comparison. While we appreciate that much may be learned from the metrics used by the Colorado Division of Insurance, the data collected is self-reported and the Division has a limited scope of regulatory authority, which excludes the data gathered as

a comparable source. We will continue to look for other statewide benchmarks as data improves, to the extent that it is valid and applicable.

9. **Comment: It is difficult to understand how rate comparison data factored into conclusions about network adequacy. For example, it is unclear which 10 codes were used for the basis of comparison between Medicaid and private payer rates.**

Response: Pursuant to the federal regulation 42 CFR 447.203(b)(3), the Department is directed by the Centers for Medicare and Medicaid Services (CMS) to aggregate the top ten applicable procedure codes for each benefit category to conduct the comparative payment analysis. While the data is available via normal public disclosure protocols upon request, it is not required to be included in the Plan.

10. **Comments: The Department must do a better job of soliciting access input from stakeholders and should explain the types and frequency of Medicaid member complaints it receives via the Customer Contact Center.**

Response: The Department is responsive to concerns about access and is committed to enhancing its capabilities to track, trend and synthesize the various streams of information it receives from Regional Care Collaborative Organizations, managed care contractors and other sources, to ensure access to services.

The Department has added additional information within this Plan regarding: the types of calls the center receives; and the improvements to Customer Contact Center ticket categorization the Department is exploring, which may allow for better identification of specific access concerns in the future.

The Customer Contact Center is just one source of many that gathers input from stakeholders regarding access. The Department holds over thirty stakeholder meetings per quarter in which concerns about access are raised and addressed. Reference Figure 9 in the Plan for a diagram of the existing stakeholder feedback mechanisms and Figure 5 to view a workflow of how access issues are addressed.

Additionally, pursuant to federal regulation 42 CFR 447.203, the Department is required to solicit and consider input from members, providers, and other affected stakeholders concerning access to care whenever a State Plan Amendment includes a proposed rate reduction or restructuring. This new process is outlined within the Plan.

11. **Comment: One stakeholder group suggested that the necessary data elements required to completely and thoroughly evaluate Medicaid patient's access to care in Colorado probably does not presently exist.**

Response: The Department agrees that there is no single data element or set that would sufficiently evaluate levels of access to care.

12. **Comment: Another stakeholder group acknowledged present data challenges associated with measuring access to care and asked that, as the Plan continues to evolve in coming years, several additional measures be included, such as the following clinical measures used by the**

Agency for Healthcare Research and Quality⁴ (AHRQ) and the Healthcare Effectiveness Data and Information Set (HEDIS) 2016:

- a. Proportion of Medicaid enrollees receiving age-appropriate screening services compared to other insured Coloradans;
- b. Proportion of Medicaid enrollees receiving follow up services within recommended timeframes compared to other insured Coloradans;
- c. Proportion of Medicaid enrollee children receiving recommended vaccinations compared to other insured Coloradans; and
- d. Proportion of Medicaid enrollees who had a consistent source of primary care (as opposed to frequently changing providers) compared to other insured Coloradans.

This group also suggested the first Plan include a clearly delineated list of data measures that, though not addressed presently, will be covered in future Plans.

Response: The Department collects some of this HEDIS data when evaluating service quality. We will consider how these data points intersect with the utilization data needed for this report and may use such information in future iterations of the Plan, if the data is found to align.

Demographic Considerations

Stakeholders stated the following:

1. **Comments: This report does not adequately evaluate access disparities across diverse populations (i.e. children vs. adults, or among various ethnic groups).**

Response: Pursuant to the federal regulation governing the requirement (42 CFR 447.203), the Plan evaluates utilization trends for the entire Medicaid population by provider type and site of service. The Department is not mandated to further stratify utilization by member type but, rather, to consider the characteristics of pediatric, adult and disability populations, when assessing the sufficiency of access to care. This is demonstrated in Figures 10, 51, 88, 122 and 157 throughout the Plan.

The Department does recognize the value such analytical stratification could bring to the task of measuring access and will consider incorporating such metrics in future iterations of the Plan.

2. **Comment: Individuals with disabilities experience access issues to primary and specialty care services that are not represented in the report, particularly in some parts of the State, such as the Western Slope. Some primary care providers administer lengthy applications before accepting patients and screen out patients with disabilities. Other individuals with disabilities are accepted into a primary care practice but cannot always be seen as needed, causing emergency room use. Many individuals with disabilities continue to experience difficulty in securing Home Health Services, such as 24 hour backup, care at odd hours, care 365 days a year, and providers equipped to work with difficult members.**

Response: The Department is aware of some of these screening practices in the community and we are using all tools at our disposal, including working with our Regional Care

Collaborative Organizations, to ensure Medicaid member access. The Department acknowledges the difficulties individuals can face when accessing their health care benefits. Every effort is made to ensure the Medicaid program is as accessible as possible for every member, while being especially cognizant of members with disabilities.

3. Comment: The Department should dedicate resources to help Medicaid members with disabilities resolve complex barriers to access.

Response: The Department contracts significant resources for community case management support through, for example, the Accountable Care Collaborative, Single-Entry Points, Community Center Boards, and Behavioral Health Organizations. The Department acknowledges that members with disabilities and/or chronic health conditions face challenges navigating the health care system because of their complex health care needs. There continue to be standing stakeholder meetings where these issues may be and are addressed monthly.

Service-Specific Considerations

Stakeholders stated the following:

1. Comments: Report excludes sufficient analysis of access to dental and mental health. For example, it does not include: existing CHAS data on dental and mental health visits; mention lack of treatment for autism, other developmental disabilities and brain injuries; or analysis of service utilization and outcomes within the BHO system.

Response: Pursuant to federal regulation 42 CFR 447.203, the Department is not required to assess access to care for the dental benefit or for benefits delivered through the Behavioral Health Organization (BHO) managed care system, nor for specific diagnoses within the categories of benefits that must be analyzed, such as autism, development disabilities or brain injuries. The Department's administrative service organization for the dental benefit, DentaQuest, and each BHO, is required to maintain a sufficient provider network and each is governed by other regulations which preclude them from the Plan analysis. The purpose of the Plan is to assess access for the five broad categories of services listed in 42 CFR 447.203, and to establish procedures for ongoing monitoring of access to services in general.

2. Comments: Access to specialty care is inadequate. Stakeholders cited their own service-specific and regional (HSRs 16 and 19) data and experience, and also data presented in the report. For example, the CHAS data reported indicates that Medicaid enrollees surveyed were significantly more likely to have trouble finding a provider (20% Medicaid v. 6% commercial insurance v. 9% other public insurance).

Response: The Department acknowledges the CHAS sampling data concerning member difficulty finding a specialty provider. This sample survey data does not necessarily agree with administrative claims data for the entire population, which reveals steady utilization rates and, usually, increasing levels of active specialty service providers. For example, in HSR 04 (El Paso county), the number of active specialty providers increased 25% from 320 in January 2014 to 401 in June 2015. For the Department to draw the conclusion that access to

specialty services, in general, is insufficient, while factoring in data that provider counts generally increased, would be inappropriate.

The Department's access analysis identified areas of the State that require further research over time to understand atypical utilization trends, including HSRs 16 and 19. The Department will continue to monitor utilization and access patterns in these regions.

3. Comment: Analysis of access to primary and specialty care is inadequate. For example:

- a. Whether someone visited a health care professional within the past year is not an effective measure of meaningful access to primary care, particularly when that health professional may have been an emergency room provider. Better metrics could include: how long does it take someone to get an appointment with a primary care provider when they are sick; were they able to access necessary follow-up care; how far did enrollees have to travel for services; and does access differ within a geographically large HSR.**
- b. The metric "visiting a specialist in the past 12 months" provides little data about wait times or geographic access. In addition, measuring specialist access by HSR says little about the kind of specialty care available and whether there is, in fact, access to necessary specialist care.**

Response: The Department disagrees with the assertion that the analysis of primary and specialty care is inadequate. The Department applied uniform analytical standards for all categories of service in the Plan and incorporated applicable Colorado Health Access Survey data to create a more complete picture of access, in addition to administrative claims data. As the Department describes on page 11 of the Plan, analyzing access to care is complex and requires a variety of data sources, and no data point taken alone can be a reliable metric of access.

4. Comments: When measuring access to obstetrical care, there are other obstetric metrics that should be applied. One stakeholder group stated, for example, the Department should measure utilization among pregnant women. Including the whole Medicaid population does not give the correct picture. This same stakeholder group asked if it is also possible to include information on fluctuation of pregnancy rates of the general public in the HSRs to get a better picture of why penetration rates fluctuate. Another stakeholder group stated the Department should include analysis of in what month a pregnant woman is first seen for care (as suggested by the Medicaid and CHIP Payment and Access Commission). They pointed to Pregnancy Risk Assessment Monitoring System data regarding access to prenatal care in the first trimester of pregnancy, used in the updated version of the Colorado Access to Care Index, released in October 2015.

Response: The Plan analysis of obstetrical care does measure utilization for pregnant women, as well as any member receiving pre and post-natal care. Using a denominator of only pregnant women is problematic and is not data analytics best-practice.

It may be possible to include information on pregnancy fluctuation rates, but it is unclear what that information would tell us about access. In smaller HSRs, where the number of

pregnancies in a particular year may have totaled 50, ten fewer pregnancies the following year would appear as a large fluctuation, but may simply be attributable to natural variation in the pregnancy rate from year to year. The Department will consider using these and the other metrics suggested above in future iterations of the Plan.

Formatting Considerations

The Department received several stakeholder comments containing varied feedback about the format of, and explanations within, this Plan. Where able, the Department has clarified. For example, the Department has relabeled misleading graph titles, clarified the explanation of statistical significance as it relates to CHAS data, further clarified how to interpret the rate comparison tables, and provided further explanation of the types of complaints received by the Customer Call Center. Several stakeholders also pointed to anomalies in the data and analysis originally presented. The input received was used to correct inconsistencies, where appropriate.